

Open Research Online

The Open University's repository of research publications and other research outputs

Privacy in Maternity Care Environments: Exploring Perspectives of Mothers, Midwives and Student Midwives

Thesis

How to cite:

Burden, Barbara (2007). Privacy in Maternity Care Environments: Exploring Perspectives of Mothers, Midwives and Student Midwives. PhD thesis The Open University.

For guidance on citations see [FAQs](#).

© 2007 The Author



<https://creativecommons.org/licenses/by-nc-nd/4.0/>

Version: Version of Record

Link(s) to article on publisher's website:

<http://dx.doi.org/doi:10.21954/ou.ro.0000ea20>

Copyright and Moral Rights for the articles on this site are retained by the individual authors and/or other copyright owners. For more information on Open Research Online's data [policy](#) on reuse of materials please consult the policies page.

oro.open.ac.uk

Privacy in Maternity Care Environments:
Exploring Perspectives of Mothers, Midwives
and Student Midwives

By

Barbara Burden

RN, RM, ADM, PGCEA, MSc

Submitted for the Award of:

Doctor of Philosophy

Pertaining to the Disciplines of:

Midwifery, Nursing and Health

March 28th 2007

NOTE NO: T0301669
DATE OF SUBMISSION: 28 MARCH 2007
DATE OF AWARD: 18 JULY 2007

Abstract

This thesis explores the concept of privacy in maternity care environments through the beliefs and perceptions of mothers (during pregnancy and after birth), student midwives and midwives. The study was designed in response to practice concerns raised by midwives and an increase in professional healthcare documentation, highlighting the need to maintain and enhance the privacy of patients. Literature reviewed showed a sparse understanding of the concept of privacy in relation to healthcare and highlighted disparity between subject disciplines' interpretations of privacy. A grounded theory methodology was used to explore participants' interpretation of privacy in relation to their experiences, thus interpreting it from the perspective of users of the service and healthcare professionals.

Data collection methods included focus groups, interviews, and participant observation. Results show that mothers do have several areas of concern about privacy and base their perceptions of privacy on their ability to retain credibility as a mother when in the company of others and are linked to their perception of 'loss of face', whereas midwives consider mothers' privacy in relation to their perception of the environment as a place of employment. Students' perceptions of privacy were based on their own prior personal experiences and their knowledge as soon-to-be midwives, seeing themselves as a voice for both mothers and midwives. Recommendations for practice are provided and a new practice based tool is designed with a view to helping midwives determine and address the privacy needs of mothers. The research concludes with recommendations for those involved in the provision and development of care for mothers and for subsequent research.

Statement

No part of this material offered has previously been submitted by me for a degree or other qualification to this or any other university or institution.

I agree that the work, if approved for the degree in question, can be deposited in the University Library and (a) may be made available at the discretion of the Director of Library Services and (b) may be photocopied at the discretion of the Director of Library Services.

Contents

Abstract	i
Statement	ii
Contents	iii
List of Tables	vi
List of Diagrams	vii
Chapter 1: Introduction	1
Researching Privacy in Maternity Settings: Setting the Scene	2
Overview of the chapters	4
Initial Research Aims	6
Chapter 2: Privacy: Review of the Literature	8
The Primary Literature Search and Review	9
Exploring the Literature	10
Privacy in Context	11
Historical Definitions of Privacy	11
Privacy as a Quantifiable Concept	13
Statutory and Professional Regulation and Policy in Midwifery	15
Privacy in Society and the Home	16
Privacy and the Individual	20
Autonomy	20
Respect for the Individual	22
Privacy of the Body	24
Solitude, Isolation, Withdrawal, and Personal Space	26
Disclosure of Personal Information	27
Privacy and Healthcare Policy Documentation	31
Safety, privacy and dignity in mental health units	31
Protecting patient information	32
Essence of Care	32
Conclusion	35
Chapter 3: Research Design and Methodology	37
Establishing the Research Design: a two phase process	38
The Initial Research Design	39
Ethics Approval and Design Modification	41
The Final Research Design	45
Data Collection Methods	46
Focus groups	47
	iii

Observations	52
Interviews	55
Analysing the Data	57
Coding, Theoretical Notes and Memos	59
The development of categories	64
Ensuring Reliability and Accuracy within the Research	67
Conclusion	70
Chapter 4: Mothers' Perceptions of Privacy	72
Privacy within a Public Environment	73
Eavesdropping and Disclosure Privacy	83
Overhearing and Being Overheard	84
Overhearing Personal Information	89
Overhearing Practitioners during an Emergency	92
Disclosure of Personal Information in Records	93
On Bodily Exposure: Privacy and Loss of Inhibition	94
Loss of Inhibition and Objectification of the Body	95
Being Looked at and Watched: Issues with visual privacy	102
Being Grabbed: Inappropriate touch	105
Conversations Across Me	107
Conclusion	109
Chapter 5: Privacy: Midwives' Views	112
Privacy of the Body	113
Management of Bodily Privacy	113
Observing Mothers	118
Partners Observing Physical Examinations	119
Touch and its Role in Privacy	121
The Role of Relationship Building in Privacy	123
The Environment of Care	124
The Impact of Environment on Privacy	124
Overcrowding and Visitors	125
The Need for Personal Space	127
Right of Entry	130
Disclosure Privacy	133
Conversations during Examinations	133
Disclosure of Personal Information	134

Discussing Cases at Work	137
Midwives' Perceptions of Self Privacy	139
Conclusion	143
Chapter 6: Privacy: Students' Views	146
'Women with their bits and bobs everywhere'	147
Shyness and Dignity	147
Being Viewed During Bodily Exposure	149
Exposure of Body Fluids	156
Treating Others as you Want to be Treated Yourself	158
The Environment of Care	161
'Everyman and his dog came in': the notion of personal space	161
Disclosure of Information	167
Documentary Privacy	172
Improving Privacy: The Role of the Student	175
Improving Privacy through Friendship and Social Etiquette	176
Being a student	179
Conclusion	180
Chapter 7: Implications for Changing Practice	182
Privacy within Care Environments: Differing Perspectives	182
Loss of Face: Mothers' Perceptions of Privacy within Maternity Care Environments	183
Midwives' Views on Privacy in Maternity Care Environments	193
Students' Perceptions of Privacy in Maternity Care Environments	197
Revisiting the Essence of Care Benchmark Statements: Recommendations for Improving Practice	200
Developing a Privacy Tool for Practice	205
Conclusion	208
Chapter 8: Conclusions and Reflections	210
Recommendations for Future Research	213
Policy Recommendations arising from the Research	216
References:	219
Appendix 1: Consent Form	236
Appendix 2: Focus group schedule checklist	237
Appendix 3: Publications and Conference Presentations	239

List of Tables

Table 1: The Essence of Care benchmarks for privacy and dignity (NHS 2003)	33
Table 2: The process of data collection and analysis in grounded theory adopted for this research	47
Table 3: To show sample characteristics of the focus group sample	51
Table 4 To show participant observation activity	52
Table 5: To show the place of observation, time allocated and number of participants engaged in interactions	53
Table 6: To show number of interview participants	55
Table 7: Interviewees area of midwifery practice at time of interview and their professional grade	57
Table 8: Observation Extract and Open Coding	59
Table 9: To show open coding and extract from the theoretical notes	60

List of Diagrams

Diagram 1 To show amendments to original research design	45
Diagram 2: Extract from Atlas.ti to show axial coding or mothers in pain	61
Diagram 3: Extract from Atlas.ti to show selective coding for mothers in pain	62
Diagram 4: Extract from the theoretical memo 'Overhearing someone in pain'	63
Diagram 5: To show preliminary concept map for People Moaning – overhearing others in pain (mothers)	64
Diagram 6: To show the sub-categories within the category The Hunt for Personal Privacy: withdrawal and solitude	67
Diagram 7: To show the segment model of privacy needs template	207
Diagram 8: To show privacy considerations required during a vaginal examination	207

Chapter 1: Introduction

Privacy is a term frequently cited as a crucial component of our social existence, however little is known about its day-to-day construction or definition in relation to healthcare. Privacy is often discussed in the press and media as something to which everyone has 'a right' and as something we continually strive to achieve, with a limited understanding of what this 'right to privacy' entails. Privacy is often portrayed by the media as an issue for the rich and famous, relating to so called 'breaches in privacy' usually involving the filming or photographing of individuals in compromising situations such as, on holiday, drunk or being arrested. However, at some point in our lives most of us perceive our privacy to have been compromised; this may be linked to receipt of junk mail, unsolicited telephone calls from cold callers, finding that information about us is held on computers or having our home invaded by burglars. In most instances personal privacy is protected by removal from situations of compromise, such as, moving when someone sits too close to us in public places, the perceived level of invasion of our 'comfort zone' determining whether we move or remain. However, what happens when individuals are unable to ensure that their privacy needs are met? What is the outcome of a lack of privacy and does lack of privacy actually exist? If individuals are unsure of what privacy is, can it be considered to be compromised?

This thesis presents the results of a research study into privacy within maternity care environments, where participants were users of the maternity service (termed mothers within this document, irrespective of gestation of pregnancy or days in the puerperium), student midwives and midwives. The aim was to explore mothers' perceptions of privacy throughout their pregnancy and early period of mothering, and relate this to the perceptions that student midwives and midwives had of mothers' privacy needs to determine if a disparity existed. Exploration of privacy literature uncovered a vast array of inter-related concepts and ideas, such as solitude, embarrassment and dignity. A small literature search and review were undertaken at the start of the research to meet the needs of an application to the Local Research Ethics Committee, followed by focused searches once theoretical sampling and analysis of data commenced. As emerging concepts were explored within the research even more complex components were exposed, leading to more challenging and interesting areas to explore through the literature. What commenced as a small and succinct research project has grown in to a wealth of information on a complex and captivating subject.

Researching Privacy in Maternity Settings: Setting the Scene

On many occasions during my experience as a midwife I have heard women describe how they *'came in to the maternity unit with their dignity and left without it'* or that they *'left their dignity at the front door and collected it on the way out'*. Informal discussions with mothers and midwives regarding this phenomenon appeared to link this loss of dignity with a perceived lack of privacy during pregnancy and in particular, on admission to hospital. Mothers were of the opinion that as numerous people had viewed their bodies during their pregnancy *'no part remained secret'* and thus access to their bodies was outside of their control. Why mothers were of this opinion midwives associated with constant exposure of mothers' bodies throughout pregnancy and particularly during childbirth. This suggested that if mothers were covered and not exposed during pregnancy and labour then they would perceive their privacy needs as being met, but is it as easy as that? In order to explore whether mothers' privacy needs are met exploration of the concept of privacy was required to ascertain how mothers construct their version of privacy. By understanding definitions and variations of privacy and by exploring when breaches occurred and why, a picture of the components of privacy could be created to address this important component of care.

My interest in privacy started while working as a midwife on a local maternity unit when I was party to midwives discussing how they had noticed a change in mothers' behaviour in wards. Mothers, they claimed, had started to pull curtains around their beds during the day staying hidden for long periods of time. Discussions focused on midwives' anxiety over not being able to view mothers at a glance and the impact of this on their safety. Midwives concluded that mothers undertook this activity to ensure isolation from their roommates and therefore it was intrinsically linked to their need for isolation. Midwives' perceptions were that all mothers wanted single rooms and in an attempt to achieve pseudo-rooms curtains were pulled around beds. Their perceptions related to a view of society where individuals have become intolerant of others, resulting in a reduction in interactions with neighbours and an increase in protection of seclusion, through withdrawal from surrounding events. The need for mothers to have their own environment midwives considered to be in direct contrast from ten years earlier when women were cared for in large open wards. Ward layouts at that time were 'Nightingale style' ranging from 8 to 30+ beds running in two rows along the sides of a large open ward; in comparison most wards today are smaller, containing 4 to 6 beds with a shared en-suite toilet and wash room. Open plan ward design, midwives perceived, promoted social interactions between mothers following the birth of their babies, encouraging

support networks and learning from each other in the early days of motherhood and were thus essential to development of their new role.

During informal discussions with staff the word privacy was frequently inserted into conversations without clarity as to its meaning or interpretation, frequently being associated with ensuring confidentiality of, and access to, written records and reducing physical exposure of the body. This raised the question, how do midwives know these components are as important to mothers as midwives perceive them to be? The answer is that we have no idea; therefore any research needed to ask mothers for their interpretation and construction of privacy as it related to them, in an attempt to unravel the concepts involved and enable midwives to enhance women's care.

As discussed later, maternity provision operates within a framework of national policy within the NHS, which is intended to adapt to changing expectations (DH 1997a; DH 1998a; DH 1998b; DH 1999; DH 2000). The policy imperatives at the time this thesis commenced related to dignity and single sex ward provision (NHS Executive 2000; DH 2003). Ironically, this was still high on the Department of Health's agenda at the closure of the project, following an increase in complaints relating to the lack of single sex accommodation (DH 2005). As the project unfolded the NHS Modernisation Agency introduced *Essence of Care* benchmarks for privacy and dignity for implementation within hospitals (DH 2001a). Small groups of employees within hospitals found themselves charged with producing and implementing benchmark statements to meet these government standards. These benchmark statements varied considerably across Trusts as staff attempted to interpret privacy in relation to their area of expertise. These included ensuring Velcro was available on bed curtains (Ah-Fat 2004), access to interpretation services (Lawson 2004), and personal space and room decoration in mental health care wards (Parrot 2005).

Any national policy framework is sited within regulatory arrangements within which nurses and midwives work as a profession and from which one might expect to gain guidance. All midwives work to a Code of Professional Conduct, adherence to which is a condition of their professional registration (NMC 2004a). It was presumed that these professional documents would offer some explanation or advice on privacy and its interpretation into practice, however they offered little in relation to privacy, apart from issues relating to maintaining a patient's dignity and confidentiality of records (UKCC 1992; UKCC 1996; UKCC 1999). This highlighted the question, how is privacy

recognised and promoted in clinical practice? If the components of privacy are currently unknown within clinical practice areas, how can its achievement be measured? Do mothers and midwives have the same perception of what constitutes privacy in maternity care encounters? What criteria would mothers use in deciding if their privacy had been maintained? Have mothers ever been asked if this component of their care has been achieved to their satisfaction? All these questions were posed at the start of the research and became the foundation for the exploration of privacy shown within the following chapters.

Overview of the chapters

The following chapters present this research project in a methodical and structured order and, as with any research, this approach was not consistent with the eclectic process undertaken. Within this research, literature was not collected prior to commencement of data collection but during the research itself and in response to theoretical sampling and theory development. However, the organisation of this document is structured to aid the logical presentation of information to the reader.

The literature relating to defining or interpreting privacy is complex and varied. There was no one source for ready access and so identification of literature became a complex act of detection and retrieval, in association with theoretical sampling and analysis. With this in mind Chapter 2 of this thesis is divided into two sections. The first provides an overview of the initial literature search undertaken at the start of the project to meet the Local Research Ethics Committee (LREC) requirements for research proposal content (see Chapter 3). This initial search and review included professional documentation and classic psychology and sociology papers on personal space and the private/public divide and developed as additional literature was explored, as the research developed. The second section of the chapter focuses on literature relating to new concepts identified during data collection and analysis. These sources included primary research, policy publications, anecdotal evidence and historical documents.

Once the decision had been made to explore the concept of privacy, the next stage was to determine an appropriate methodology through which to obtain and analyse the data. Chapter 3 presents the structure of the research design, and the rationale for the use of grounded theory methodology and methods, which included focus groups, interviews and field observations. The

chapter highlights how the research was adapted in response to the requirements of the LREC which impacted upon the sample and the methods adopted, such that they were no longer in keeping with the initial proposed design.

The results are presented in chapters 4 through 6. These chapters describe mothers' perceptions of privacy during their experiences in the maternity services, from being newly pregnant to becoming a new mother. The approach taken in this project was to ask, listen to and observe mothers, to give them a voice in an aspect of care that needed to be addressed within this environment. Mothers were asked how they perceived, promoted and maintained their privacy within different areas of the maternity services (not just during the birth), and the overall impact these played in their interaction with professionals. Of particular interest was the impact of an emergency birth on mothers' view of their privacy, where there was a distinct difference between a mother who was undergoing a 'normal' birth and her counterpart experiencing an obstetric emergency (see Chapter 4). In Chapter 5 midwives outline their perceptions of the privacy needs of mothers during contact with the maternity services and include their own perceptions of privacy, which impinge on the privacy care they provide. My earlier discussions with midwives provided support for involving them in the study to determine if privacy related issues identified as being important by mothers were the same as those identified by midwives; if they were not then midwives may be missing an important component of care when supporting women. By including midwives in the study it enabled a direct comparison to be made between what mothers *actually* wanted in relation to privacy care and what midwives *thought* mothers wanted. This is followed in Chapter 6 by data on the experiences of mothers as described by student midwives, many of whom were mothers themselves. Student midwives for reasons which become clear in chapter 3, while not initially part of the study, were recruited first as part of the pilot study and then as participants in their own right. This posed questions relating to the professional development of students and whether their personal experience influenced their progress from novice carer and in many cases a mother, to being a midwife. A discussion of the perceptions of the three groups is outlined in Chapter 7 exploring the extent to which mothers and their carers have the same or disparate perceptions of mothers' privacy needs. The chapter includes a review of the *Essence of Care* benchmarks for privacy and offers advice for midwives on the implementation of privacy enhancement strategies in clinical practice. In the concluding chapter (Chapter 8) an evaluation of

the methodology and methods used are presented with an outline of my recommendations for subsequent research.

Initial Research Aims

At the commencement of the research two research aims rather than questions were identified.

These were to:

- Explore the parameters of privacy in relation to mothers within the maternity environment and assess how they promote, achieve and maintain privacy during and after pregnancy; and
- Examine privacy from the perspective of midwives to determine how they perceive, promote, achieve and maintain privacy for mothers in their care.

An initial exploratory focus group undertaken with student midwives, to gain experience in the method, identified a wealth of additional data, so the decision was made to include them in the study, thus a third aim was added, mirroring that of midwives:

- Examine privacy from the perspective of student midwives to determine how they perceive, promote, achieve and maintain privacy for mothers while working with midwives.

The research objectives were to:

- Determine whether a model (or models) of privacy that incorporated common themes identified by mothers and midwives could be designed for application to any care environment;
- Observe and record individual privacy achieving strategies and mothers' perceptions of these actions within care environments;
- Identify key privacy-maintenance strategies undertaken by mothers within care settings and the reasoning for these actions;
- Recognise incidents where privacy was prevented or inhibited;
- Categorise the resulting effects of 'non-privacy' events;
- Analyse these effects and outline recommendations for future midwifery practice;
- Examine how midwives and students interpret the privacy needs of mothers and the strategies they employ to promote and maintain privacy for mothers;
- Review and create a definition(s) of privacy from mothers' and midwives' perspectives.

The initial literature search and review helped structure exploratory questions at the start of the research; to include, what is privacy and how can it be defined in midwifery practice? Is it an issue for practice and if so, is it being adequately addressed? How do we know what privacy means to individuals, particularly women who are pregnant or have just had a baby? In periods of admission to hospital is a mother's ability to promote and maintain salient dimensions of privacy decreased? These questions fed into questions posed during theoretical sampling and theoretical memo development during data analysis (see Chapter 3).

In order to unravel the mysteries associated with defining privacy, Chapter 2 commences with literature collected from a range of subject disciplines pertaining to privacy to position the concept within existing debates and research external to healthcare, and within current debates in healthcare itself.

Chapter 2: Privacy: Review of the Literature

This review is presented in two phases; the primary literature search and review undertaken at the start of the project, to meet LREC requirements, which built upon literature referenced in my previous study (Burden 1998). The second phase commenced following the introduction of theoretical sampling and analysis of data as the research unfolded and was driven and directed by emerging concepts and theories. While the chapter embodies the literature obtained at the start of the project, which influenced some of my initial thoughts, ideas and data collection, this is followed by an in-depth review of literature obtained throughout the research. To assist understanding of the constructs involved in the complex phenomenon of privacy the decision was made to present the literature review in its entirety early in the documentation and revisit it again when presenting the data in Chapters 4 - 7. This enabled the range of information relating to privacy, which was not directly relevant to the aims of this research, to be presented to position it within the wider arena of evidence and so aid a greater understanding of the general concepts involved.

Collecting literature prior to commencing the research posed initial challenges for the research design as there is debate within grounded theory research as to whether prior practical knowledge or knowledge gained from literature, is beneficial (Strauss and Corbin 1998a) or detrimental (Glaser 1992). Within grounded theory, the literature search and review are usually undertaken as data is collected and analysed, being driven by emerging concepts and theories. While having no prior experience or knowledge of the subject is often portrayed as the ideal, in reality this is not always possible and so it is important to acknowledge the impact prior information has on the research design (Strauss and Corbin 1998a). In relation to this project, my previous research and inherent literature review, acted as a foundation for this research and could not be ignored (Burden 1994; Burden 1998). It had been my initial intention to explore the literature later in the project, building upon this previous work, as theoretical sampling and analysis commenced. However, this had to be amended due to pressure from the LRECs which stipulated that a literature review be compiled at the proposal stage (see Chapter 3); therefore an initial literature review of privacy in healthcare and related disciplines was completed, which, while rather modest in content, concentrating on historical, psychological, sociological and legal documents, met the requirements necessary to proceed.

The Primary Literature Search and Review

The primary literature search on privacy within healthcare settings, revealed approximately a dozen publications, only two of which were primary research sources. No midwifery related publications were found apart from my original papers on privacy strategies within maternity wards (Burden 1994; Burden 1998); therefore the search was extended to cover other subject disciplines, such as psychology, sociology and law (Westin 1970; Young 1978; Dahlen *et al.* 1987). In recognition of the breadth of terms relating to the concept of privacy abounded within the varied disciplines, further and more flexible key words were adopted. Through terms such as, privacy, private, seclusion, withdrawal, exposure and solitude, a broader and more extensive body of literature was exposed (Basford and Downie 1990; Moorbath 1993a; Chadderton 1996; Arslanian 1997; Bell 1998; Sharts-Hopko 1998; Bird 2003). These are outlined within this section and where appropriate presented in more detail later in the chapter.

In relation to healthcare literature it was envisaged that, due to the intimate nature of nursing and midwifery practice, statutory and professional rules and codes of practice for nurses and midwives would embody guidance on achieving and maintaining privacy in care environments (UKCC 1992; UKCC 1996; UKCC 1998; NMC 2004a). In fact these documents yielded little to enable practitioners to interpret the components of privacy, or aid understanding, interpretation and application to everyday practice. Anecdotal material on privacy, from healthcare practitioners, while offering no explanation as to its maintenance or definition, generally stated that it should be maintained in clinical settings (Curtin 1986; Curtin 1992). While these documents gave generalised statements on the need to maintain a person's dignity or privacy they did not add any significant information to the developing debate.

In respect of primary literature emerging from the discipline of law, the privacy debate tended to focus on the human right to expect privacy (Milligan 1987; Davidson 1990; Marr and Pirie 1990; Rowan 1993) and the meaning of privacy as a human right enshrined within the American Constitution of Independence (Alderman and Kennedy 1997; Garrow 2001). Such literature refers to cases of precedence following a number of court cases in the USA challenging the right to privacy or the lack of it, which had set the scene for current definitions of privacy in use today (Westin 1970; Young 1978). However, more recent sources at the time the research commenced focused on issues of privacy relating to information retrieval, storage and access, with emphasis on

surveillance and data storage (Bennett 1991; Regan 1993; Agne 1994; Reiman 1995; Samoriski *et al.* 1996; DeCew 1997; Introna 1997; Klein 1997; Nissenbaum 1998; Schatz Byford 1998; Markesinis 1999; Kateb 2001; Meaney 2001; Rosen 2001b; Akdeniz 2002; Majtenyi 2002; Salecl 2002; Ferguson and Wadham 2003; Pitt-Payne 2003; White 2003; Lederer *et al.* 2004). This extensive literature relating to information technology is not addressed within this review, as it is extensive and outside of the scope of this research.

Literature from the disciplines of psychology and social science emphasised the human right to expect privacy. Here the papers indicated a universal agreement that privacy was every individual's right but tended not to define the term privacy or definitively address questions relating to its meaning or constituents (Milligan 1987; Davidson 1990; Marr and Pirie 1990; Rowan 1993). Although the problem of defining privacy remained complex, interest in the concept of privacy had been examined in respect of personal space (Moore 1984; Barron 1990; Moore 1998), group solidarity (Kelvin 1973) and extended to the public/private debate (Elshtain 1982; Garmanikow *et al.* 1983; Willcocks and Peace 1987; Gavison 1992; Lopata 1993; Fahey 1995; McCulloch 1997). This initial literature, while rather sparse, identified privacy as varied and interpreted from the perspective of each subject discipline. It was only as privacy was explored further as issues arose from the data that the complexity of privacy emerged.

Exploring the Literature

Once the primary literature search and review was completed for the research proposals, the process of a more detailed search and review commenced as ideas were generated from data through theoretical sampling and analysis. Key terms, such as, private, privacy, personal space, dignity and solitude were applied to healthcare databases, CINAHL, Medline, Ovid and Ebsco and a library search was undertaken to identify key texts associated with privacy (Hek 1994; Lott 1995; Holmes 1996; Kirk-Smith 1996; McGuire 1997; Hart 1998; Loy 1999), the process of which was published in the British Journal of Midwifery (Burden 2001). Theoretical sampling was used within the research therefore literature was reviewed as collected, to assess applicability to the developing concepts and theories. As the project evolved the breadth of the review increased and a bibliography database of over 650 articles and books was created using Endnote, a computer-based bibliography package. To inform and prepare the reader for what follows the review is presented in a logical order rather than true to the research design, which would have required

presenting the literature as it was collected chronologically. This balance is redressed within Chapters 4 -7 when concepts emerging from the literature in relation to the data are re-presented. This chapter is therefore divided into four sections reviewing the context of privacy from an historical, legal and statutory perspective, followed by privacy within society, its application to the individual, through to its application to healthcare through policy documentation, interpretation and implementation.

Areas identified for inclusion related to problems of defining privacy, the public and the private debate, privacy norms, privacy and power, cultural influences, therapeutic relationships, personal control and autonomy, confidentiality and disclosure of information, body searches and exposure, personal space and the environment. Inherent to these discussions were the concepts of intimacy, dignity, trust, respect, autonomy, choice, solitude and personal space. Literature contributing to this review were derived from a range of subject disciplines revealing differing discipline related debates, for example, within law the drive was to construct a quantifiable, measurable definition of privacy which could be proven or refuted within court proceedings (Westin 1970; Young 1978); within psychology, the concern had been to link privacy concepts with personal space and overcrowding (Freedman *et al.* 1971; Desor 1972; Freedman *et al.* 1972; Rustemli 1992), whereas sociological debates focused on the effects of institutionalisation and presentation of the self within the public/private divide and in relation to feminism (Goffman 1961; Goffman 1963; Goffman 1967; MacKinnon 1983; Hansen 1987; Pateman 1989; Gavison 1992; Scott and Keates 2004).

Privacy in Context

Setting the context for privacy is not easy to achieve as historically legal and sociological definitions and concepts have altered according to current perspectives. This section outlines the historical viewpoint on privacy through the ages followed by more current debates from law. The discipline of law has until the late 1900s led the way in defining privacy following the need to quantify the term in order to allocate levels of privacy breach, to financial compensation or punitive measures. Once the legal frameworks for privacy were in place they were used as a foundation for healthcare professionals' statutory framework, in order to inform and monitor practice.

Historical Definitions of Privacy

The term private has evolved from the Latin word *privatus* considered to mean withdrawn from public life, or from *privare* meaning bereaved or deprived (Williams 1976; Spacks 2003), associated

with an act of deprivation or denying a person their liberty or personal space. The first historical references to privacy as a source of deprivation suggested that to be isolated or deprived of the company or interaction of others within society, was associated with being a 'non person' or having a loss of humanity.

'In ancient feeling the privative trait of privacy, indicated in the word itself was all-important; it meant literally a state of being deprived of something, and even of the highest and most human of man's capacities. A man who lived only a private life, who like the slave was not permitted to enter the public realm, or like the barbarian had chosen not to establish such a realm, was not fully human.'

(Arendt 1958:38)

The gradual association of privacy with privilege and limited access for the populous, rather than a sense of deprivation, occurred throughout the 14th to 16th centuries, with redefinition occurring across the centuries; for example, in the 14th century privacy referred to the voluntary withdrawal of religious orders whereas, by the 15th century the term private was being used to identify persons not holding an official position or rank (as in private soldier) (Williams 1976). By the late 15th century private became linked in opposition to the term *public* denoting concealment in areas such as, politics, sexual encounters or activities (Spacks 2003). By the 16th century *private* had become allied with the sense of withdrawal, seclusion, independence and intimacy, whereas in the late 18th century it was commonplace for strangers frequenting local taverns to share rooms and even the same bed without feeling compromised. Bayne-Powell (1937:82) explained:

'We must remember that over-crowding was characteristic of the age. Well-to-do people thought little oftwo sleeping in a bed. The pupils of expensive boarding schools were herded together under the most unsanitary conditions. Servants slept in the kitchen or lay on the staircase and passages. Travellers at inns would share rooms and beds with total strangers. Privacy did not seem to be valued even by those who could insist upon it. The eighteenth century was too near the age when solitude was dangerous, and men congregated in herds for mutual protection.'

In English culture today the notion of communal living relates to privatisation of the nuclear family where families have become insular and protective of their own space and solitude (Felipe and Sommer 1966; Allekian 1973; Stratton et al. 1973; Kerr 1985; Barron 1990; Lopata 1993; Fahey 1995). More recently in the 20th century privacy (or more specifically seclusion) has become synonymous with protection of the individual and autonomy from the *public* and considered a right in relation to civil liberty and a sense of intimacy with associates (Reiman 1976; Williams 1976; Gerstein 1984; Inness 1992; Boling 1996).

More contemporary definitions of privacy as a personal right (Westin 1967; Jones 1974) as a feeling (Bates 1964), and as a state of being (Kelvin 1973; Boone 1983; Schoeman 1992) rather than an imposition or deprivation are evident in many descriptions of privacy. Coontz (1988) describes privacy as the state of being private and undisturbed from intrusion or public attention, and avoidance of publicity. It is also described as *'belonging to oneself'* and as a sense of freedom (Halmos 1953; Pennock and Chapman 1971; McHale and Gallagher 2003). These are however descriptions of conditions of privacy, rather than definitions. There remain questions as to whether privacy is an individual right or emerges from other compounding variables, such as human dignity and autonomy (Benn 1971; Gross 1971; Simmel 1971; Bloustein 1984; Prosser 1984), intimacy (Inness 1992), shame (Schneider 1977) or in the creation and preservation of the self (Goffman 1959; Reiman 1976).

Privacy is also considered by some to be a psychological state of solitude or being apart from others (Halmos 1953), a form of power or control we have over information held about us, control over one's own affairs or control over information circulated about us (Parker 1974; Introna 1997; Nissenbaum 1998). Control over the status of privacy is also perceived as a means of social control; particularly within institutions (Applegate and Morse 1994; Rich 1995; Scott *et al.* 2003c). Whether this applies at the individual level is debatable (Margulis 1977) however, the ability to conceal information about oneself from another is instrumental to the development of relationships with others and is central to the privacy debate (Curtin 1993). The concept of control is also managed through the legal system where the drive is quantification.

Privacy as a Quantifiable Concept

Common interpretations of privacy emerging from legislation and law are aimed at defining privacy as a quantifiable concept, measurable against common standards, in order to determine grades of privacy breach and subsequent recompense. It is suggested that it is impossible to observe privacy, what is actually observed are violations of privacy norms (Applegate and Morse 1994); however, this can only be achieved if the notion of privacy norms are known in any given situation. Definitions set on cultural norms and behaviours, but which create moral or legal precedence, incline to the process of defining privacy rather than constituents of the concept (Gavison 1984; Hudson 2003).

One of the first pieces of English legislation linked to privacy was introduced in 1361 in accordance with the *Justice of the Peace Act* in England which outlawed 'peeping toms and eavesdroppers' (Banisar 2000). The legislation aimed to punish eavesdroppers, intending to make money from selling the secrets or scandal of others, and to prevent the loss of business information and unwanted intrusion into the homes and social lives of the upper classes. Privacy guidance was further developed in the late nineteenth hundreds following the publication of the *Universal Declaration of Human Rights* (Universal Declaration of Human Rights, Article 12 1948) which focused on privacy and its link to external interference with family, home or correspondence, and attacks on a person's honour and reputation. This was followed in 1950 by the *Convention for the Protection of Human Rights and Fundamental Freedoms* (1950) which shaped the *European Commission of Human Rights and the European Court of Human Rights* (to oversee enforcement). These key pieces of legislation were followed by the publication of the *Data Protection Act* (Great Britain 1998a), the *Human Rights Act* (Great Britain 1998b) and subsequently the *European Declaration on Human Rights* (2000) all of which aimed to ensure the legal standing of individual privacy.

One of the first working definitions for law provided by Westin (1967) centred on the inner life of the individual. He divided privacy into four distinct areas; solitude, or the ability to withdraw from others, anonymity, the separation of social identity and action, intimacy, the development of relationship with some and exclusion of others, and reserve, where psychological withdrawal develops a psychological barrier against the unwanted intrusion of others (Westin 1967; Schwartz 1968; Madgwick and Smythe 1974). Other definitions emerging from law described privacy as interference in the family or home, intrusion on seclusion, interference with physical or mental integrity, attacking one's honour or reputation, disclosure of embarrassing facts, using a person's likeness, name or identity, spying or watching, interfering with correspondence or disclosure of confidential information (Prosser 1960; Pennock and Chapman 1971; Parker 1974; Rawnsley 1980; Prosser 1984; Paine 2000). Whatever definition is used it should achieve theoretical elegance and applicability. None of these categorisations embody the elements of the psychological impact of privacy breaches on the individual such as resulting mental distress. However, Bloustein (2003:5) suggests that privacy is the:

'Value our society places on protecting mental tranquillity, reputation and intangible forms of property.'

However, Parker (1974) does consider the individualised nature of privacy which determines whether a breach in privacy has occurred, suggesting that courts consider the five following questions:

- *‘whether a person has lost or gained privacy,*
- *whether he should lose or gain privacy,*
- *whether he knows that he has lost or gained privacy,*
- *whether he approves or disapproves of the loss or gain, and*
- *how he experiences that loss or gain.’*

(Parker 1974:278)

More recently privacy has been defined in terms of actions against individuals rather than the outcome. For example, Banisar’s (2000) definition of privacy attempts to categorise measurable factors into four areas; information privacy, addressing data handling of personal information held in records; bodily privacy, addressing invasive procedures; communication privacy, addressing security of correspondence and territorial privacy, addressing environmental intrusions and surveillance. However, an alternative definition by Allen (2001a) while agreeing with informational privacy as a category, offers physical privacy (to include personal space), decisional privacy (concerning choice), and proprietary privacy (concerning property interests). In addition to these categorisations, Beauchamp and Childress (1989) suggest that individuals have a role to play in maintaining or securing their privacy and are not placid and non-participatory in events and so this needs to be considered within any definition.

While the legal profession creates a standard for societal privacy the interpretation of law into healthcare legislation provides the working standards for professionals, offered through statutory and professional regulation.

Statutory and Professional Regulation and Policy In Midwifery

The statutory and professional regulation of midwives is detailed within the Professional Code of Conduct (NMC 2004a) and the Midwives Rules and Standards (NMC 2004b). Both the Code and Rules outline what is reasonably expected from a competent practitioner and determines a standard of practice. Standards of practice are also determined by various agencies within the National Health Service (NHS) and the Department of Health (DH); these include the NHS Executive, the NHS Modernisation Agency and NHS Best Practice.

In 2002 the first privacy related misconduct case set legal precedent in the UK. This case is documented on the Nursing and Midwifery Council (NMC) website at www.nmc.org.uk and has become the basis of the nursing and midwifery professions interpretation of privacy within healthcare settings. In this case the nurse was found to have:

'failed to promote his patients' dignity and privacy, allowing one patient to use the toilet while another was in the bath in the same bathroom'.

The nurse was removed from the register and *'barred from practising or calling himself a registered nurse anywhere in the United Kingdom'*. The NMC's Director of Professional Conduct, Liz McAnulty was recorded as stating:

'The NMC's Code of Professional Conduct clearly sets out nurses' responsibility when it comes to the administration of care and the protection of a person's privacy and dignity.'

The Code of Professional Conduct for Nurses, Midwives and Health Visitors was cited as evidence of the nurse's non-compliance with professional regulations on the protection of privacy and dignity:

'As a registered nurse, midwife or health visitor, you must respect the patient or client as an individual:

2.1 You must recognise and respect the role of patients and clients as partners in their care and the contribution they can make to it. This involves identifying their preferences regarding care and respecting these within the limits of professional practice, existing legislation, resources and the goals of the therapeutic relationship.

You are personally accountable for ensuring that you promote and protect the interests and dignity of patients and clients, irrespective of gender, age, race, ability, sexuality, economic status, lifestyle, culture and religious or political beliefs.'

(NMC 2004a:4)

There is no direct reference to privacy in this quoted section of the code and it lacks a prescribed or measurable definition of privacy by which to judge the level or extent of breaches. The assumption is that privacy issues are related to protecting a patient's preferences of care, rights, interests and dignity, based on social norms and expectations, as outlined in the next section.

Privacy In Society and the Home

Attempts to define privacy are further confounded when privacy is viewed as culturally defined and reliant on the context and nature of the situation (Applegate and Morse 1994; Smith 1997). A dichotomous model dividing society into *public* and *private* domains has emerged within social studies. This model locates the family in the private domain in an environment of the intimate or personal, with the wider society and its institutions being situated in the public domain, where non-

family values dominate (Elshtain 1982; Imray and Middleton 1983; Cheal 1991; Gavison 1992; Lopata 1993; Marks 1994; Bailey 2002; Kovacs 2002; Kelly 2003; Scott and Keates 2004).

Fahey (1995) challenges these notions of the family as private describing an erosion of family privacy throughout the process of social development, specifically imputing the regulatory activities of the welfare state in this process. He proposes that instead of discussing privacy in relation to preconceived images of the *private/public* divide, it would be beneficial to conclude that privacy consists of zones. He constructed a concept of privacy as a multifaceted, multi-layered labyrinth of zones and sub-zones with varying degrees of privacy embedded within them and interconnected between them. Fahey (1995) describes '*the zones of privacy*' within everyday life which hinder development of any one model of privacy. Fahey (1995) considers that all boundaries of privacy are artificially created, that is they are culturally constructed and context related. In this way each privacy encounter is circumstance and individually specific. He states:

'The argument offered here is that there are numerous public/private dualisms in social life, that they are not 'objective', externally observable givens but 'subjective' constructs shaped by the contexts in which they emerge, and thus that none has absolute a priori empirical precedence.'

(Fahey 1995:688)

He contends that the content of zones can vary as can boundaries, creating desired social barriers, such as locks on doors.

An individual's claim to privacy is central to the formation of zones which then operate to create insiders and outsiders, each zone having boundaries and potential entry requirements or specifications (Fahey 1995). According to Fahey (1995:699);

'Calling a boundary private means simply that those who define it regard it as having a special force and legitimacy: they thereby implicitly declare that the boundary is important to them and assert as a moral right that outsiders respect their wish not to be intruded upon.'

Challenges to the dichotomy of the *public/private* divide, advance the argument that privacy and intimacy are not confined to the private domain. For Fahey (1995) zones of privacy take account of the complexity of real life, any facet of privacy being related to the context in which it occurs. Zones are not restricted to, or bounded by, division of public and private. Within any given environment or situation there can be public or private spaces. The home generally classified as a private place can, if required, be sub-divided into private and public areas, for example, kitchens with free flowing

unrestricted access are often public spaces, whereas bedrooms and bathrooms may be private places free from observation allowing for secret and private activities among individuals in the same household.

The theory of privacy propounded by Fahey (1995) is one in which zones of privacy emerge as individuals respond to a given situation, but Fahey's descriptions do not provide for gender. Within feminist literature it is generally argued that the *public/private* theory of society consigns women to the private sphere, associating them with activities such as childbearing, childrearing and household chores, limiting their involvement in the wider public domain (Firestone 1979; Hansen 1987; Gavison 1992; Benhabib 1993; Stein 1993; Scott and Keates 2004). Feminist perspectives have opposed this as an artificial polarity, a cause of dysfunction within modern society and a source of social control of women. Perpetuation of the public/private theory is seen by some to encourage the unequal status of women and to foster paternal power and oppression of women in the home (Mill J Stuart 1982; Garmanikow *et al.* 1983; MacKinnon 1983; Hansen 1987; Mill 1988; Pateman 1989; Lopata 1993). Others propose an alternative perspective, that privacy within the home afforded women a mechanism for their protection against an authoritarian society (Moore 1984; Fraser 1987; Fraser 1994). Some feminists therefore, argue for the perpetuation of the public/private divide viewing the private home as a locus of power and empowerment for women, through a strong and central role within it. In such a setting women can support the development of children and be empowered as mothers, enabling them to develop strong values such as, compassion, humility, attentiveness, sensitivity, and to have a strong orientation towards preserving life in their children (Ruddick 1980; Elshtain 1982; Kelly 2003).

If location in the private domain affords women these particular advantages does this power operate in respect of their claims for and creation of privacy zones? According to Rossler (2005) the private domain of the home can be a place of autonomy, refuge and privacy where a process of '*self re-invention*' is possible enabling review and reinvention of the self in readiness for return to, and action in, the public domain. Rossler (2005:168) states:

'Our private home or room, our family, can and should be a refuge, a refuge that we value and look to not only for its own sake, but also and above all because it gives us the opportunity to be on our own, undisturbed and unseen, which seems to be vital for successfully testing, learning and seeking out (aspects of) our autonomy. Being on one's own in order to engage autonomously and authentically in the search for what one wants

and who one wants to be is clearly a central aspect of why we seek and value the privacy of seclusion.'

The achievement of privacy within society enables an individual to have a sense of personal control and autonomy, while its loss can result in disempowerment for individuals (Masud and Khan 1974). The classic texts of Proshansky *et al.* (1970) and Steiner (Steiner 1970) describe how choice is the key feature of perceived freedom and privacy within society. There is an interrelationship between a person's ability to control who has access to them and to information concerning them, and a person's ability to create and maintain different types of relationships with different people. The process involving the ability to control access to our person and our ability to make conscious decisions is associated with what Feinberg (1983) explains as '*sovereignty as a person*' or what makes us unique as individuals. Rachels (1975) argues that beneath these interactions there is a '*real*' person and that we wear '*masks*' during our daily interactions in order to '*hide*' the real us, to protect ourselves from the public. Rossler (2005) relates this to her onion model, of peeling back layers of privacy to reveal the core essentials which are individual and unique; as the core at the centre becomes more exposed the greater the individual's perceived privacy loss.

Central to the debate of control and autonomy within society is the power and constraint society or others have over the individual (Kelvin 1973). For Kelvin (1973) constraint operates when the privacy of an individual is invaded by the presence of others preventing them from functioning in a '*normal*' way; in contrast, power influences one's ability to maintain or seek one's own privacy, limiting the amount of power and control other influences can have over individuals, and is intrinsically linked with what Kelvin terms a '*location in time*'.

'In effect, an individual (or group) is in a condition of privacy whenever, and only for as long as, his behaviour is not immediately affected or determined by the influence of 'others'. Privacy, as a psychological state, is essentially a condition of the 'here and now'.... 'Privacy is not merely a by-product of absence of power: the mere absence of power-relationships is a characteristic of isolation.....an individual has privacy to the extent that others do not exert the potential or latent power they have over him.'

(Kelvin 1973:252 -254)

Privacy is therefore not just freedom from the power of others but freedom from the prospective power that may hinder its development. Kelvin's references to the experience of the individual as they perceive it indicates the subjective nature of privacy. The difficulty for any research is that it is driven by the need to study the features that create or diminish this subjective position, from the perspective of the individual.

Privacy and the Individual

In order for the individual to achieve privacy he or she must remain autonomous, feel respected and able to make informed decisions based on choice (Gross 1971; Feinberg 1983; Graneheim *et al.* 2001). Where this is not achieved the individual feels dehumanised, exposed and vulnerable heightening his or her sense of shame and embarrassment (Schneider 1977; Meerabeau 1999; Salecl 2002). This section considers the role of autonomy, respect, solitude, isolation, withdrawal and disclosure of information in relation to the individual.

Autonomy

Free from the power of others autonomous individuals are able to select, decision-make and take responsibility for their own lives:

'The kernel of the idea of autonomy is the right to make choices and decisions – what to put into my body, what contacts with my body to permit, where and how to move my body through public space, how to use my chattels and physical property, what personal information to disclose to others, what information to conceal, and more..... My right to determine by my own choice what enters my experience is one of the various things meant by the 'right to privacy' and so interpreted that right is one of the elements of my personal autonomy'.

(Feinberg 1983:21)

The role of dignity, privacy and autonomy in healthcare has been acknowledged in the NHS Plan (DH 2000) in relation to care of the elderly where it was described as *'not an addition to care provision, it is an integral part of good care'* (DH 2000:129). This is of particular importance when patients have a mental health problem affecting their identity, autonomy and security (Graneheim *et al.* 2001) and in cases where patients are compromised due to illness (McParland *et al.* 2000; Tabak and Ozon 2004).

The largest study of privacy, autonomy and informed choice in healthcare to date, concerning nursing interventions, was a three year multi-centred quantitative project funded by the European Commission (Leineo-Kilpi *et al.* 1999). Data on nursing care interventions were collected from nurses and patients in Finland, Germany, Greece, Spain and Scotland. Information on nutritional needs, elimination, medication and bodily hygiene were collected, however the areas of exploration were those identified by practitioners as important, rather than those of priority identified by users of the service. Arising from the study were publications focusing on autonomy, privacy and informed consent in surgical, postnatal and elderly care (Lemonidou *et al.* 2003; Scott *et al.* 2003a;

Scott *et al.* 2003b; Scott *et al.* 2003c) Of particular relevance here are those papers pertaining to postnatal care (Leino-Kilpi *et al.* 2002; Scott *et al.* 2003a).

Results from this study highlighted mothers' requirement for privacy during meals and during feeding of their babies which scored highly, echoing work by Back and Wikbald (1998) where patients wanted to have meals in private. Neither studies qualified what privacy meant in this context; for example, whether patients wished to have their meals as individuals or as a patient group. Questions on social and informational issues within Leino-Kilpi *et al.*'s study focused on enabling mothers to meet visitors in private, knocking before entering rooms, and enabling mothers to discuss medication in private. Overall, the findings indicated that mothers requiring interventions felt their privacy needs had not been met in comparison with those who had no interventions. An important element to consider within this current research is the findings which confirmed that staff without formal qualifications felt the privacy needs of mothers were rarely addressed, as compared with those with formal qualifications (Leino-Kilpi *et al.* 2002; Tabak and Ozon 2004).

Cultural differences in privacy needs of mothers across countries were also evident within Leino-Kilpi *et al.*'s study (2002). Mothers in Scotland for example were most happy with toileting, showering and undressing in view of others, as compared to mothers from other countries. For example, Gardener (1997) in her modern day experience of living within a Bangladeshi village community, described how her request for isolation at night was viewed with anxiety and concern by members of the family with whom she was residing, because of their concern for her safety. Any research undertaken must therefore consider the influence of societal and cultural norms on interpretations of privacy depending on its country of origin.

In an expansion from Leino-Kilpi *et al.*'s original study an eleven point privacy scale was developed for staff, taking account of the physical, social and informational concerns of mothers in Scotland (Scott *et al.* 2003a). The scale addressed whether staff had protected the mothers by, only asking questions regarding pregnancy and delivery, facilitating mothers to meet visitors in private, knocking on doors, helping with meals, ensuring mothers could breastfeed in private, ensuring information on treatments remained confidential, discussing medication, helping mothers to the toilet, taking care of personal hygiene and not exposing mothers' bodies to others. Overall, they found mothers had a more positive view on the protection of their privacy than midwives. This

supported the work of Back and Wikbald (1998) who determined that patients and nurses attached a high value to privacy in general. However, patients often entered care environments with preconceived ideas of what privacy would be afforded them. For example, patients expected that nurses would intrude on their space by open doors without knocking or asking permission.

Nurses' perceptions of intrusions into privacy of patients with chronic mental illness at home, was studied by Magnusson and Lutzen (1999). Mental health nurses in the study perceived themselves to be intruders, which in turn influenced the relationship they had with their patients. For nurses the home symbolised personal privacy and integrity and resulted in them considering invasive care as morally wrong and certain treatments as immoral impositions (Magnusson *et al.* 2002). Nurses' perceptions of their patients' autonomy were that it had a negative impact on their caring relationship, disturbing their power balance. In comparison, when district nurses were invited into the home *by* patients this perception was reduced and relationships enhanced. Differences between the perceptions of district nurses as compared to mental health nurses could be ascribed to perceptions of their patient's ability to make autonomous informed choices based on information received and understood. To achieve privacy the need for equality in relationships for the protection and maintenance of autonomy, integrity and respect is perceived as necessary (Randers and Mattiasson 2004).

Respect for the Individual

The relationship between carer and the cared for is key to the preservation of privacy and essential to any therapeutic relationship (Applegate and Morse 1994; Hutton 2002). Applegate and Morse's observational study within a residential care home described three categories of resident interrelationships; resident as friend, resident as stranger and resident as an object. Where staff viewed a resident as a friend their interactions with them were considerate, the person's right to self-determination and right to privacy being respected (Petronio and Kovach 1997; Jacelon 2003; Jacelon *et al.* 2004). Where residents were viewed as strangers, interactions were '*courteous, superficial and formal*', but the right to privacy was still respected. The relationship in this case was depersonalised and focused within a set of prescribed rules of privacy, such as using common courtesies like '*please*' and '*thank you*'. Where residents were viewed as objects, privacy needs were violated and patients became invisible or dehumanised, with privacy considered unnecessary

or unimportant. Dehumanisation can be classified as, trivium (child-like), inanimate object (the product of another's work), animal (a lower life-form) or as other (a non-person) (Vail 1966).

It could be argued that where residents had mental disabilities, such as in the study by Applegate and Morse, the outcome was influenced by the communication and social skills of subjects. There was a distinct lack of communication between residents in the study and we have no idea if this was unique to this study or normal for this type of environment. Staff respect for rights to privacy varied from resident to resident, despite the fact that all were subjected to the same possibility of dehumanisation. Privacy was respected when residents and staff acknowledged each other as people, such as during social events where the relationship was one of friendship, as the two groups became free from the confines of caring. Once the event was complete the non-verbalising patterns associated with dehumanisation returned. From this Applegate and Morse (1994:415) determined that privacy was culturally defined and '*dependent on context and situation*'. While this study provided useful insights into the functioning of privacy in institutional settings, it is noted that only male residents were observed, therefore generalisation to women or other care environments may not be appropriate.

Gubrium's (1975) 'Murray Manor' described how behavioural norms relating to privacy were linked with health. The unhealthier the individual the more privacy became task focused and depersonalised. Where clients were relatively healthy, staff knocked on room doors and waited for an invitation to enter. Where residents were mentally impaired, their rooms were left open and their privacy needs not given priority. Where the carer came to know the individual and treated them with respect then dehumanisation reduced, with sincere and caring individuals feeling guilty if violating another's privacy (Knepfer and Johns 1989). The greater the process of dehumanisation the less guilt a carer experienced when invading another person's privacy (Knepfer and Johns 1989). Applegate and Morse (1994) observed that within institutional settings of care homes the drive to complete daily work tended to outweigh staff considerations of residents privacy, with aspects of the institutional setting conflicting with privacy norms of individuals. These included a legal requirement for 24 hour access to residents' rooms and communal facilities such as common bath and shower rooms. The carer/resident relationship was perceived by the individual as friendly or intimate, or in some cases intrusive, when encounters between carer and resident were perceived as violating cultural norms. Any therapeutic relationship between carer and patient

breaches privacy norms because of the need for touch and bodily intrusion inherent to nursing practice (Lawler 1991).

Privacy of the Body

In Western society individuals generally choose privacy and seclusion for bodily examinations, physiological functions of excretion and reproduction. When undertaken in public these personal activities usually result in feelings of loss of control or embarrassment (Moore 1998; Margalit 2001). One of the most significant breaches in bodily privacy was documented in America in the 1960s where police and prison services were routinely subjecting women to body cavity searches, including vaginal and rectal examinations, at police stations following arrest (Alderman and Kennedy 1997). Public outcry followed radio broadcasts by women outlining this imposed assault on their person and the resulting sense of shame and debasement they experienced. Experience working with patients in mental health settings who were also subjected to body searches, both on admission and during their stay, lead Alexis (1986:22) to propose that:

'To be actionable, the invasion must be of a nature to cause outrage, mental suffering, shame, or humiliation to a person of ordinary sensibilities.'

Being witnessed during periods of intimacy is deemed an intrusion on the person. Privacy has been described as a state of intimacy (Reiman 1976; Fried 1984; Gerstein 1984; Reiman 1984; Inness 1992) and within healthcare is inherent to confidentiality of the body and the person (Jourard 1966; Jourard 1967; Curtin 1986; Lawler 1991; Synnott 1992; Brooks and Lomax 2000). Western culture presents individuality as the right to be free from intrusion, with intrusion deemed the primary weapon of the tyrant within society and often associated with imprisonment and interrogation (Arendt 1958; Bloustein 2003). The environment influences the type and amount of intrusions received and our ability to gain isolation or withdrawal as required.

The sense of intrusion caused by the presence of a spectator during the birth of a baby was powerful enough to lead one mother to pursue a court action in America (Bloustein 2003:12):

'The intrusion is demeaning to individuality, is an affront to personal dignity. A woman's legal right to bear children without unwanted onlookers does not turn on the desire to protect her emotional equanimity, but rather on a desire to enhance her individuality and human dignity. When the right is violated she suffers outrage or affront, not necessarily mental trauma or distress. And, even where she does undergo anxiety or other symptoms of mental illness as a result, these consequences themselves flow from the indignity which has been done to her.'

Part of the process of this indignity is linked to shame and embarrassment individuals perceive resulted from exposure and viewing of the body. Shame relating to covering and uncovering, speech and silence, concealment and disclosure are described as policing control of exposure of the human body. Three stages of shame were identified by Schneider (1977) as linked to modesty, sincerity and naturalness. Shame is perceived as occurring only when an action is witnessed by others suggesting that it can never be an individual state of mind (Rykwert 2001). However it could be argued that acts undertaken in private result in shame in individuals because of social or cultural morals. Shame involves personal components that make us individuals and its relationship to privacy demonstrates that privacy involves more than purely physical bodily realms.

Unwarranted intrusions into personal space may result in individuals being seen in compromised situations through the physical presence of intruders, unwanted observations, dispersion of private information about individuals, the spread of inaccurate or misleading information and encroachment on personal decisions (Sommers 1959; Tate 1980; Curtin 1986). Curtin suggests that not being able to make decisions is an unwarranted intrusion on privacy linked to individuals, their current environment and their responses to surrounding social norms. When an individual is compromised it is proposed that their ability to make decisions is impeded (Jourard 1966; Lawler 1991; Richards 2001). Compromised health compounded by prevailing environmental conditions cause the erosion of an individual's power and will to claim privacy. Elderly people, for example, are less likely to complain and adapt to their circumstances and become more compliant when in hospital (Barron 1990) relinquishing ownership of their bodies to practitioners (Rachels 1975; Lessig 2002). Rachels equates this to a form of '*property rights*' which overtakes the basic human need for and claims to, privacy, enabling practitioners to intervene and take over that role.

There is a fine balance between ensuring an individual's privacy and the manners or etiquette of carers (Moore 1998). A comparative study of hospital care for elderly patients in Sweden and Nottingham monitored knocking on doors prior to entering, door closure, the use of commodes and nursing attitudes towards privacy (Barron 1990). In relation to physical activities patients in the study confirmed that curtains were not pulled around the beds for activities such as micturition and defaecation. Patients also stated that nursing staff did not speak before re-entering the curtained space around their beds, did not close toilet room doors once they were on the toilet, and did not

consider their dignity when assisting them to wash (Barron 1990; Travers *et al.* 1992; Twigg 1999), resulting in a lack of solitude for important aspects of bodily care.

Solitude, Isolation, Withdrawal, and Personal Space

Solitude, withdrawal and isolation are associated with privacy, the interpretation of which, as negative or positive experiences, depends on the extent to which individuals' autonomy and choice are operating in relation to them; it is the perception of privacy being achieved that is important not the event. Solitude is usually associated with a sense of gratification and pleasure at being away from others; whereas, isolation has negative connotations, being associated with stress and punishment and has a long association with torture for prisoners and the enforcement of compliance (Westin 1967; Meehan *et al.* 2000). Isolation in healthcare can also be applied positively to segregation of patients to protect them or others in cases of serious infection. However, isolation usually involves loss of autonomy, representing the power and control imposed by others on the individual. Proshansky *et al.* (1970) and Steiner (1970) suggest that isolation can also be self imposed when an individual becomes so embroiled in themselves or their actions that they fail to interact with others. Alternatively, withdrawal is perceived as a voluntary act, a choice for privacy of body or mind with freedom to move between periods of interaction or withdrawal; for example, Spacks (2003) suggests that individuals create private worlds in their mind in which to withdraw, such as during the simple process of immersing oneself in a book.

Privacy claims are evident in the appropriation of personal space within hospital settings (Peace 2003; Peace and Reynolds 2004a; Peace and Reynolds 2004b). Patients assume their personal space and territory relate to their immediate environment, such as the bed, locker and bed table, however, this territory was not perceived by healthcare workers as belonging to the patient (Woogara 2004:35 - 36):

'Such territory and space were frequently compromised by healthcare practitioners who did not close bed curtains fully and peeped through them even when intimate care was being carried out, thus leading to embarrassing situations for patients..... Sitting on the patient's bed without his or her consent was a frequent occurrence by both doctors and nurses. It was equally common for staff to access patients' personal belongings either in or on their lockers without seeking permission.'

The outcome of a lack of personal space has been shown to cause a change in mood associated with a dissatisfaction of hospital environments and with territorial intrusions (Johnson 1989), with mothers in single rooms documenting lower mood disturbances than those in multiple bedded

rooms (Janssen *et al.* 2000). Lack of personal space and overcrowding has been shown to influence competence and task completion (Desor 1972; Rustemli 1992; Nijman and Rector 1999) and when applied to ward environments reduces mothers' ability to rest.

The problem of privacy in healthcare settings is compounded by social norms relating to male and female spaces and has directed research attention to mixed sex wards (Fisher and Bryne 1975; RCN 1993; Burgess 1994; Cole 1995; Langlands 1997; NHS Executive 1997; NHS Executive 2000; DH 2005). In psychiatry and care of the elderly, wards have traditionally been mixed to reproduce so called socially normal conditions. Their introduction to general wards was, ostensibly, for more efficient use of clinical areas enabling the allocation of patients on the basis of need or risk, rather than gender. Analysis of The Nursing Times survey (Burgess 1994) showed patient concern over: not being informed that wards were mixed sex prior to admission, close proximity of individuals of the opposite sex and the lack of privacy particularly in toilets and bathrooms. As strength of feeling prompted self-selection of respondents, with many reporting that the pleasure of admission overrode the prevailing conditions experienced, the inclusion of bias within the study should be considered.

Even today debates on single-sex accommodation continue following record numbers of complaints from patients regarding this aspect of care. Following the NHS Executive's position paper titled *'The Patient Charter: privacy and dignity and the provision of single sex hospital accommodation'* (NHS Executive 1997), a supplementary circular outlined the abolishment of mixed sex wards if privacy and dignity of patients could not be achieved. However, the need to ensure maximum bed occupancy cannot be achieved if beds are allocated according to gender within dual-sex wards. This has similar problems to the allocation of beds to mothers in labour. In practice beds are kept for labouring mothers to ensure they are placed together. However in reality beds are required for all mothers and so segregation cannot be maintained or ensured in periods of heightened activity.

Disclosure of Personal Information

The ability to choose what to disclose to others, especially intimate details, is central to the maintenance of personal privacy (DH 2003). In disclosing even a small facet of our private lives in return for care, trust is placed in those to whom we disclose. Some health information has the

potential to be harmful in emotional terms, such as, ridicule, deprivation of rights, relationships or social standing (Badzek *et al.* 1998). In healthcare settings disclosure of sensitive information from client or patient to the nurse or midwife maybe crucial to the care they receive (Back and Wikbald 1998). It is the process and handling of the disclosure that determines the individual's level of perceived privacy loss. Lazarus (1969) described five levels of disclosure privacy: the inner area of private territory, where no information is shared; information that may only be shared with the closest of friends or relatives; layers of information shared with friends and then acquaintances and a final level with social contacts, each level moving to a more open level of broadcast. Confidence in their right to control information about them, even after divulging it to carers, and assurance that their identity and information remain confidential, encourages individuals to contribute information which will inform their care (Woogara 2001) and forms the basis of trust between patient and carer.

For a relationship to develop there needs to be an inferred promise of confidentiality, respect and trust between patient and carer (Curtin 1986; Ormrod and Ambrose 1999; Rylance 1999; Petchey *et al.* 2001; Dimond 2003; Deshefy-Longhi *et al.* 2004). This promise enables a reality to be created in which trust operates. If a person does not trust the healthcare practitioner then they may choose not to disclose crucial material, or may inadvertently mislead the carer. The difficulty is compounded because mutual self-disclosure, essential to a trusting relationship, is not necessarily present in healthcare relationships where most information is one way from client to carer. Inferred confidentiality by the professional alters the client/carers sense of reality in relation to their partnership, and enables an artificial intimacy to develop (Gerstein 1984; Curtin 1986; Inness 1992). This sense of altered reality is so important to the individual that any breach of disclosure of information is a breach in care, important enough to end their bond (Rylance 1999; DH 2003). Curtin (1993) also suggests that, contrary to popular belief, a trusting relationship does not occur within a 3 – 4 day hospital stay. She asserts that healthcare professionals delude themselves if consider they have developed a trusting relationship with a client in such a short space of time.

While trust is important to the relationship, personal information is perceived by patients as the property of the person and permission should be sought from the individual prior to its disclosure. In healthcare settings, hallway conversations, unattended computer screens and answer phone messages containing personal details are implicated in potential breaches of privacy (Deshefy-Longhi *et al.* 2004). For example, Petchey *et al.* (2001) found that 67% of doctor's receptionists

asked patients for personal details and reasons for their visit within range of other patients, thus breaching their privacy.

It can be argued that within healthcare, situations exist where the individual's right to confidential preservation are outweighed by the need to protect others. In situations of child abuse (Burden and Wenman 2004) or domestic violence (Kelly 2003) professionals have an obligation to protect the needs of children or the abused (Etzioni 1999). It could be argued that reporting of such matters is public reporting rather than public disclosure. Often these activities are covert and it is no defence to argue that to explore these events is an invasion of one's privacy. Where events are illicit, the right to privacy is forfeit, particularly to recognised authorities:

'Challenges to privacy are often launched on the grounds that some of the reality it cloaks is illegal, immoral, unjust, inefficient or in some other way unacceptable – in other words, that the reality it permits lacks legitimacy and so is not entitled to be safeguarded from intrusion.'

(Fahey 1995:696)

Each individual, it is suggested, has an inner core of privacy secrets that is never shared with other people (Curtin 1992), although in trying, urgent or desperate circumstances, intimate disclosures may be made. However, disclosure of intimate personal information may increase stress and anxiety and promote resistance unless the reason for the required disclosure is provided in detail. The way in which professionals utilise this information determines whether relationships develop into one of trust and further possible disclosure. By risking disclosure patients must believe that the professional is in a position to help and will not breach their confidence. With this in mind Curtin (1993:27) advocates that hospital personnel should:

- 'Collect only the amount of data necessary to the treatment of that person or family;
- Explain thoroughly why the information is necessary and to what use it will be put;
- Remember that patients' consent is necessary whether or not the procedures, questioning or treatment ordinarily require written consent;
- Exercise great caution in the discussion or dissemination of information about patients'.

The average individual perceives his or her medical records to be confidential and requires them to remain that way (Rachels 1975), as disclosure of their personal life or behaviour may not only cause embarrassment but also have other ramifications (DH 1997b; DH 2003).

'The average patient does not realise the importance of the confidentiality of medical records. Passing out information on venereal disease can wreck a marriage. Revealing a

pattern of alcoholism or drug abuse can result in a man's losing his job or make it impossible for him to obtain insurance protection.'

(Rachels 1975:324)

The classic and founding example is provided by Warren and Brandeis in 1883 where Warren's private and domestic life was violated and made public following a detailed press report, which included photographs of a private family function (Post 1991). Warren and Brandeis' argued that the severe mental pain and distress caused by this breach of privacy was, in their perception, more destructive than physical injury. They, and subsequently Prosser (1960), concluded that the resulting mental cruelty was worse than slander of character or reputation. This case established that the psychological impact of an intrusion on privacy was more harmful than other forms. Prosser conferred that privacy protects the individual from *'intentionally inflicted emotional trauma'* and therefore privacy is really about hurt feelings and loss of reputation which is of material value (Bloustein 1984). Bloustein proposed that privacy was more complex than this, relating it to a spiritual level that influenced one's mental state on a higher plain. He advises that privacy should not be concerned with private property but as Warren and Brandeis propose with an *'inviolable personality'* concerning one's independence, dignity and integrity, as determined by one's uniqueness and self-determination (Bloustein 1984; Post 1991). It is suggested that what prompted Warren and Brandeis to write their article was the fear that the press would devastate their *'individual dignity and integrity'* and emasculate their *'individual freedom and independence'* (Bloustein 2003:10). Thus part of the problem is associated with what is now described as defamation of character.

Defamation of character is perceived as an insult or injury to the individual and his or her standing within the community and is thus material. This psychological invasion of privacy results in an assault on the individual's perception of him or her self and is therefore considered by some as harmful. Privacy is perceived not as a unique value but as a composite of interests in reputation, emotional tranquillity and intangible property (Prosser 1960). The element of control over personal information is central to many definitions of privacy such as that afforded by Rosen (2001a):

'By privacy, then, I mean the ability to exercise control over personal information, and by personal information, I mean information over which I reasonably expect to exercise control'.

and Curtin (1992:7)

Privacy is not simply an absence of information about us in the minds of others, rather it is the control we have over information about ourselves.'

Curtin (1986) suggests that intrusion is at its peak when personal thoughts, feelings, actions and interactions are exposed and analysed by others, including minute details of the case. Consent should be gained from individuals before disclosure otherwise professionals could be accused of a breach of professional ethics. In normal circumstances informed consent is usually sufficient to obtain consent to disclose, however, this must be directly linked to the vulnerability of clients and the manipulative skills of the professional. In therapeutic relationships the type and content of information offered to professionals may be such that the opportunity for manipulation and coercion of clients is possible, therefore healthcare policy is put in place to ensure the safety and wellbeing of patients.

Privacy and Healthcare Policy Documentation

Healthcare policy documentation is linked to both EU and UK law interpreted into practice. In accordance with this legislation, hospitals and community trusts have to evaluate the potential risk of breaches in privacy and be proactive in protecting the privacy of their users (Glen and Jownally 1995). At the time of this research three policy documents relating to privacy were in place, relating to single sex accommodation in mental health wards (NHS Executive 1997; NHS Executive 2000), protecting patient information (DH 1997b) and *Essence of Care* benchmark statements (DH 2001a).

Safety, privacy and dignity in mental health units

Maintaining the privacy and dignity of patients with mental health concerns came to the forefront following the publication of the document *Modernising Mental Health Services* (DH 1998c) in which the government set out its strategy for improving mental health provision. This resulted in the publication of the guidance document, *Safety, privacy and dignity in mental health units* (NHS Executive 2000) outlining the policy for mixed sex accommodation in relation to building design and layout, confirming that all new units must provide single bedrooms with locked doors and direct access to toilet facilities. The overall aim was to prevent members of the opposite sex having access to gender specific rooms and bathrooms. While this has no specific relationship to this research it highlighted the professions views on privacy, linking it to bedrooms and toileting facilities.

Protecting patient Information

With the introduction of the computer age, data can be readily shared between computer systems and across Trusts. The NHS has agreed to move towards a computerised record scheme which offers sharing of data across a range of departments and agencies. The Caldicott Committee, 'set up to review all patient-identifiable information which passes from NHS organisations in England to other NHS or non-NHS bodies', produced the Caldicott Report (DH 1997b:1). The report identified weakness in the way the NHS handled confidential patient data and made 16 recommendations for improving practice. The report recommended the appointment of Caldicott Guardians, existing members of staff with the remit of ensuring the security of patient data (DH 2001c). These individuals are supported by the NHS Strategic Tracing Service (NSTS) who work with a national database of information required by Trusts, health authorities and general practitioners (DH 2001b). In response to Department of Health concerns relating to patient information and access, the DH published *Confidentiality: NHS Code of Practice* (DH 2003) as the ultimate guidance on patient confidentiality which should now underpin professionals' practice.

Essence of Care

The NHS has given attention to patient privacy in the NHS Modernisation Agency *Essence of Care* benchmarks on privacy and dignity (DH 2001a). Privacy and dignity had been identified as areas for improvement within the *NHS Plan* (DH 2000) following general criticism that nursing care had been neglecting basic care provision and skills. This prompted the Department of Health to publish *The Essence of Care* (DH 2001a:1) described as a:

'tool to help practitioners take a patient-focused and structured approach to sharing and comparing practice.'

The aim was to promote best practice using ideas and views of staff and users of the service through national benchmark statements that identified standards of care for users' experiences.

Eight areas of basic nursing care were initially identified as central to nursing and midwifery practice: continence, bladder and bowel care, personal and oral hygiene, food and nutrition, pressure ulcers, privacy and dignity, record keeping, safety of clients with mental health needs in acute health and general hospital settings, and principles of self care. These were later extended to include communication (NHS 2003). The benchmarking process recommended a PDSA cycle (Plan, Do, Study, Act) with stages including: agreeing best practice (as in the benchmark), assessing clinical practice against best practice, producing and implementing an action plan,

reviewing achievement, disseminating improvements and reviewing the action plan, and agreeing best practice again.

The benchmark statement for Privacy and Dignity has an agreed patient outcome on *'care that is focused upon respect for the individual'* and offered the following definitions for practitioners, privacy or *'freedom from intrusion'*, dignity or *'being worthy of respect'*, modesty or *'not being embarrassed'* and personal space or where the *'patients set boundaries for psychological, physical, emotional and spiritual contact'* (NHS 2003:1). While these are good starting points for definitions, they incorporate traditional privacy definitions from authors such as Young (1978) and Westin (1970). However, at the time when *Essence of Care* was constructed there were no definitions of privacy specific to healthcare and, more importantly, only limited research relating to privacy in healthcare on which to base the standards.

The benchmark statement for privacy and dignity is divided into seven factors, including statements on best and poor practice; as presented in the table below:

Agreed patient-focused outcome			
Patients benefit from care that is focused upon respect for the individual			
	Factor	Poor practice	Benchmark of best practice
1.	Attitudes and behaviours	Patients experience deliberate negative and offensive attitude and behaviour	Patients feel that they matter all of the time
2.	Personal world and personal identity	Patients' individual values, beliefs and personal relationships are never explored	Patients experience care in an environment that actively encompasses individual values, beliefs and personal relationships
3.	Personal boundaries and space	Patients' personal boundaries are deliberately invaded	Patients' personal space is actively promoted by all staff
4.	Communicating with staff and patients	Patients are communicated at	Communication between staff and patients takes place in a manner which respects their individuality.

5.	Privacy of patient- confidentiality of patient information	Patients' information enters the public domain without their consent	Patients' information is shared to enable care, with their consent
6.	Privacy, dignity and modesty	Patients' privacy, dignity and modesty are not considered	Patients' care actively promotes their privacy and dignity, and protects their modesty
7.	Availability of an area for complete privacy	Patients and or carers are denied access to any area which offers privacy	Patients and or carers can access an area that safely provides privacy

Table 1: Adapted from The Essence of Care benchmarks for privacy and dignity (NHS 2003)

Each of the seven factors is then sub-divided into indicators of best practice to stimulate discussion within groups of practitioners and users. For example, factor 6, which includes privacy, dignity and modesty, is divided further into:

- *'patients are protected from unwanted public view for example by using curtains, screens, walls, clothes and covers;*
- *appropriate clothing is available for patients who cannot wear their own clothes;*
- *Policies are in place for patients to have access to their own clothes;*
- *Patients' can have a private telephone conversation;*
- *Modesty is achieved for those moving between differing care environments.'*

(NHS 2003)

To date three Trusts have explored the privacy and dignity benchmarks in relation to: a lack of information on religious groups and interpretation services (Lawson 2004), the use of Velcro to ensure closure of bed curtains (Ah-fat 2004) and improving environment and space in mental health settings (Parrot 2005). While the link to privacy is in some instances tentative, when considered in relation to the benchmark content, it is possible to determine the pathway adopted by staff.

The factors linked to privacy and dignity benchmarks associated privacy and dignity with: being cared for, values, beliefs and relationships, a need for personal space, good communication, sharing of information, protection of modesty and seclusion. On review of the documentation, it could be argued that practitioners were left to identify areas of concern which may not reflect the underlying needs of users of the service.

Conclusion

From the literature commonalities within privacy have emerged which offer a starting point for its review in maternity care settings. Fundamentally privacy is viewed as a basic human need and a human right; privacy is what the individual claims it to be, and that claim is influenced by temporal and experiential factors operating on that individual. Claims for privacy are influenced by the cultural milieu of individuals and norms of the immediate setting and wider society, with individuals present in the immediate setting and involved in similar activities, perceiving privacy issues in entirely different ways.

The review of the literature reveals concern to understand the concepts of privacy through the disciplines of law, sociology and psychology. Legal definitions are pragmatic developments seeking resolution of legal problems and in some cases there is recognition of the material harm caused by the psychological impact of perceived breaches in privacy. Within the field of sociology, privacy is entangled in complex sociological theory and discussions difficult to relate to healthcare situations. The same applies to the approaches in psychology, although theories emerging come closer to the lived experience of individuals, particularly where research is conducted in healthcare settings.

Today's midwives are provided with codes of practice and guidelines which inform and advise on how to conduct the practice of midwifery. These are emphatic about the limits of practice and the qualities practice should embody. These are weighty matters for the midwifery practitioner who turns increasingly to statutory documents to help negotiate the social, psychological and increasingly, the legal minefield of day to day midwifery practice. As discussed these documents do not give definitive advice about privacy itself, nor is it defined within them, although the contents of these documents maybe used as a basis from which to censure the midwifery practitioner where breaches in privacy are perceived. In relation to the Department of Health benchmark statements, the midwifery practitioner is not well served by them as they are problematic to interpret and to implement in practice.

The most interesting theory of privacy to emerge from the literature, and one which resonates with my own personal experience of midwifery practice, is that of Fahey (1995) who attempts to deal with the complexity of privacy. Fahey describes privacy as dependent on the claim for privacy prompted by individuals' experiences and circumstances. These privacy claims are made from the

individuals' perspective and relate to the significance of events as they are experienced by them.

As argued by Fahey (1995) it could be suggested that childbearing mothers constantly re-create and redefine their zones of privacy, the content and boundaries of these zones adapted to their perceptions and the interplay of other levels and facets of privacy at any given time.

Privacy in the maternity care environment, it is hypothesised, is subject to all of the complexities of individual experience, conflicting perceptions and temporal influences arising from life changing events. In such a context any research approach needs to be free of the constraints imposed by formal methods of data collection, to enable real life experience of individuals to emerge for explication. A methodological approach which allows theory of privacy to emerge directly from the experience of subjects and through their voices, rather than to be imposed, was seen as the most likely to achieve a meaningful theory of privacy and therefore, grounded theory was adopted as an appropriate methodology for this study.

Chapter 3: Research Design and Methodology

The strands of literature presented in Chapter 1 related to the topic of privacy explored throughout the research and in response to emerging analytical categories and theoretical sampling of data. Complementary to this review of privacy is a review of the literature pertaining to grounded theory as a research methodology, which is presented within this chapter to show how it underpinned the research design. The aim was to select an approach which explored privacy through the words, experiences and actions of participants and so quantitative approaches were excluded in the early stages of the design. Grounded theory was deemed appropriate on two counts, firstly, that the methodology offered a way of thinking about and studying social reality based on data collected from the words and actions of participants. Secondly, it provided a medium through which to describe and explore this little known phenomenon in healthcare, enabling theories to emerge from data (Glaser and Strauss 1967; Strauss 1987; Glaser 1994a; Glaser and Strauss 1994a; Strauss 1994a; Charmaz 1994b; Glaser 1994b; Glaser and Strauss 1994b; Strauss 1994b; Glaser 1994c; Glaser 1994d; Glaser 1994e; Glaser 1994f; Glaser 1994g; Glaser 1994h; Strauss and Corbin 1997; Strauss and Corbin 1998a; Strauss and Corbin 1998b; Dey 1999) since:

'Theory derived from data is more likely to resemble the 'reality' than is theory derived by putting together a series of concepts based on experience or solely through speculation.....'

(Strauss and Corbin 1998a:12)

Since grounded theories drawn from data are more likely to:

'offer insight, enhance understanding, and provide a meaningful guide to action.'

(Strauss and Corbin 1998a:12)

Grounded theory methodology is similar to other qualitative approaches in relation to the methods used, such as participant observation, interviews and more recently focus groups, but differs in the approach taken to sampling and data analysis. In grounded theory, analysis of data occurs after each data collection episode, in order to highlight further areas for exploration through theoretical sampling. The sample is selected in response to emerging theoretical perspectives at each analytical stage, complemented by constant comparison of data, used to ensure saturation of categories. Throughout data collection and analysis theoretical memos are compiled, first as conceptual notes and then as theoretical concepts or explanations, as more substantial theories emerge. These ideas and concepts identify areas of further exploration during each subsequent

data collection episode. The overall aim of grounded theory methodology is the generation of theory relating to the topic of study, which is then presented as a story through core themes.

This chapter focuses on three sections, the first of which describes the initial research design, the modifications made to the design in response to external influences, and why decisions were made to include not only mothers and midwives, but ultimately student midwives. Section two describes the data collection methods, with the final section containing details of the process of data analysis, through theoretical sampling, theoretical memos, constant comparison of data, conceptual codes, axial coding to the development of categories and eventual core categories. The conclusion offers an overview of the issues developed throughout the chapter and outlines the parameters of the research.

Establishing the Research Design: a two phase process

The original aim of this research was to explore parameters of privacy in relation to mothers within maternity environments and assess how they promote, achieve and maintain privacy during and after pregnancy. Grounded theory facilitates the emergence of theoretical frameworks as the research evolves and utilises theoretical sampling and constant comparison of data. Although exploratory questions were posed at the start of the research, in keeping with grounded theory, no specific research questions were formulated as the methodology supports the emergence and retirement of questions throughout data collection and analysis. This approach requires questioning to become more issue specific as the research progresses (Strauss and Corbin 1998a) and as concepts, sub-categories and categories emerge. Throughout the analytical process categories are refined, and in some instances merged with others, until the point where no new categories emerge and theories develop through theoretical memos (Strauss and Corbin 1998a).

Grounded theory was first introduced in the 1960s following the publication of Glaser and Strauss' *Awareness of Dying* (Glaser and Strauss 1965). This research explored the views of patients dying of cancer and presented the now classic research design used in grounded theory methodology, that of theoretical sampling, constant comparison of data collected from interviews and participant observation, theoretical saturation and the eventual formation of core categories (Glaser and Strauss 1967). Grounded theory methodology is not new to the NHS having being used to explore issues relating to healthcare, for example, decision making (Clark 2004), learning to nurse children

(Coetzee 2004), parenting stress (Heneghan *et al.* 2004), nursing intuition (McCutcheon and Pincombe 2001), and complexity of care (Tishelman *et al.* 2004). It has also been used more specifically in midwifery in relation to the role of fathers during pregnancy (Donovan 1995) and in an exploration of early motherhood (Barclay *et al.* 1997). The first book associated with this methodology in nursing is the classic text of Chenitz and Swanson (1986:14), who stated that its use in theory development would create a greater understanding of the '*world of nurses and their clients*'.

There is debate amongst grounded theorists (see Chapter 2) as to whether researchers should have knowledge of the topic prior to commencing the research because of any possible bias it may bring to data collection or analysis. Prior professional and privacy experience is acknowledged within the research as an important source of additional data enriching data analysis (Strauss and Corbin 1998a), rather than an influence which impinged upon or distorted the researcher's ability to collect and analyse data according to the words of participants (Glaser 1992). In practical terms my prior research was acknowledged (Burden 1994) as a foundation on which this project was designed.

The Initial Research Design

The initial design proposed for this research intended to employ interviews and participant observation of mothers and midwives, to explore how they perceived, promoted, achieved and maintained privacy in the maternity environment (as you will read in this chapter the groups were later amended to include student midwives). It was proposed that a comparison could then be made between what mothers actually wanted in relation to their privacy needs and what midwives perceived those needs to be. The aim was to undertake a period of observation of mothers to explore their world while in the care of the midwife, to facilitate the exploration and collection of further data within interviews, as theories developed. It was initially proposed that one mother would be selected for the first interview followed by traditional theoretical sampling as lines of enquiry arose and theories were generated. Since grounded theory does not utilise a predetermined sample size, as sampling is led by the emerging theory and continues until the point of theoretical saturation (Glaser and Strauss 1967), no precise sample size was speculated in advance. This is known as theoretical sampling, the aim of which is to generate theory by collecting, coding and analysing data prior to further data collection, so that theory generation is

always data-led and controlled by the emerging theories (Glaser and Strauss 1967). In keeping with theoretical sampling, it was envisaged that data analysis would be ongoing throughout the research. Atlas.ti, a computer-based data package, was used for the management of data analysis. Data would be primary coded, working through to the creation of a core category, or the story, as the theory developed. Throughout the analysis stage data would be subject to constant comparative data analysis and theoretical memo writing, ensuring the generation of theory (Glaser 1992; Strauss and Corbin 1998a; Dey 1999).

At the initial stage of the research development, two NHS Trust hospitals were selected for potential access. I had access to both sites through my employment thus recognising the data potential of each site. It was envisaged that accessing these sites would result in concurrent data collection from field observations and interviews with mothers and midwives. It was recognised that the study would be subject to time constraints set by my employer who granted me a period of sabbatical leave in which to collect data. Data collection was planned to commence with participant observation in both community and hospital settings to ensure immersion into the culture and activities of participants, through my engagement in the field. It was envisaged that this would facilitate the selection and interview of the first research participants. Formal applications were thus made to two NHS Trust hospital sites Local Research Ethics Committees (subsequently called Trusts 1 or 2 and LREC 1 or 2).

The first Trust (Trust 1) served a large community with a diverse range of social and ethnic groups. The birth rate was approximately 4,500 per year. The hospital provided a small antenatal clinic, dealing mainly with obstetric cases. It had two antenatal/postnatal wards, a delivery suite and obstetric theatre and a regional neonatal intensive care unit. Community midwifery within this site was divided into two working teams each with its own methods of care, thus within the community there was team midwifery, caseload midwifery and traditional community care. There was also provision for specific groups such as, teenage mothers or those with HIV. The second Trust (Trust 2) was a local hospital covering a large area of new housing developments. The birth rate was approximately 2,500 per year with provision including a delivery suite, antenatal clinic, a postnatal ward and an antenatal ward. Community midwifery was divided into four teams each working within a defined geographical area.

In pursuit of the initial design Trust midwifery managers, clinical directors and Research Directors were contacted by telephone to inform them of the research. These conversations were followed by meetings and culminated in securing letters of support from these gatekeepers. In Trust 1 project meetings, so that senior midwifery staff could be informed of the research, were also held at their request in preparation for ethics approval.

Ethics Approval and Design Modification

The initial research design was subject to a number of changes during the early stages of the research process in response to external sources, and in particular the Local Research Ethics Committees (LREC). Receipt of the application forms from the two NHS Trust hospitals' LRECs made it clear that the documentation related to large medical randomised controlled trials and was not conducive to a qualitative study. After consultation with the Trusts Research Directors to discuss how my grounded theory methodology might be handled, it became clear that the research proposal would not be allowed to proceed to the LRECs review panel unless a detailed proposal was developed, to include a literature review, an outline sampling strategy and most importantly, a designated sample size. This had an immediate impact on the structure of the research as it had not been my intention to commit to a specific sample size or undertake any further review of the literature until theoretical sampling had commenced (Glaser and Strauss 1967; Strauss and Corbin 1998a). In practice, the various strands of literature outlined in Chapter 1 were summarised for the research proposals submitted to the two LRECs and did not impinge greatly on the research, as expansion of the literature following theoretical sampling added a greater dimension. To conform to the LRECs' second requirement, theoretical sampling was outlined within the proposal and in keeping with the Directors' recommendations, an estimate made of the prospective sample size. In retrospect, the sample size of eight focus groups with mothers from local user groups, 30 interviews with mothers in hospital, 40 interviews with midwives, plus participant observations, was too ambiguous and unrealistic, but met the Research Directors' requirements enabling the research to proceed to the ethics committee stage. In practice the research incorporated theoretical sampling of data and was not led by the need to fulfil quotas.

Preliminary research proposals were sent to each Research Director along with copies of the proposed information sheets and consent forms (MacInnes 1999) (see Appendix 1). Agreements from both Directors that the research proposal would be reviewed by their LREC were received

within 6 weeks. The LRECs identified a number of issues for consideration at their meetings some of which were easily addressed, for example, ensuring informed consent during participant observation (McCall and Simmons 1969; Lofland and Lofland 1984; Alder and Alder 1998; Emerson *et al.* 2001), inclusion of vulnerable groups (Ezeh 2003), and the destruction of the audiotapes on completion of the research (Seidman 1998; Keats 2000). As shown below, two further issues were identified which had a greater influence on the study, which included the committees view of adopting a more *'favourable experimental design'* and secondly, replacement staffing costs for attendance for interviews.

Both LRECs raised the issue of informed consent in relation to observation activities and the need to inform participants of their rights prior to participation. Informed consent is based on the concept of autonomy through which participants are able to decide whether to participate in the research or not (Lindsey 1984; MacInnes 1999). In relation to this research the debate focused on ensuring informed consent from all potential participants involved in data collection activities during field observations. Information sheets and consent forms had been prepared for use with interviews, informing participants of the research, their right to withdraw at any time and their right to have the data destroyed if requested (Swanson 1986; Seidman 1998). However, the debate within the committee focused on whether to inform all mothers in the clinical area that observations were taking place, or just those directly involved. This raised the issue that if mothers were directly informed of the observation would they alter their behaviour (Johnson 1992; Spouse 1997)? It was agreed with the LRECs that posters would be displayed in clinical areas, on the days when data were being collected, informing participants of my presence and of the research. Included on the poster was information on how participants could be excluded from the study and who to contact in order to achieve this; in practice no participants requested to be excluded during the study.

Debate took place within LREC 2 regarding the inclusion within the study of vulnerable mothers and mothers if English was not their first language. My initial proposal stated that unconscious mothers, those in severely compromised conditions or those who could not speak English would be excluded from the study, the rationale relating to mothers being unable to give consent because of their condition or circumstances (Johnson 1992; Emerson *et al.* 2001). The debate focused on whether these mothers should be included, as the potential for their privacy to be compromised was perceived to be greater than for others. The possibility of observing a mother in a severely

compromised condition is rare in midwifery practice, so the chance of a mother being included in the study was possible (and did not occur), but atypical, and so this was agreed even though I could not ensure that consent could be obtained. The finances available to support the research did not include funds for an interpreter and it was therefore deemed unethical to include non-English speaking mothers in the research without prior informed consent, which appeared to be in conflict with the inclusion of vulnerable mothers.

Of the three issues identified as easiest to address the destruction of audio recordings was easy to confirm for LREC 1. It was agreed that once the research was completed and all interviews transcribed then the audio tapes would be destroyed in keeping with their requirements.

The more difficult issues raised by LREC 2 involved restructuring the research design to a randomised controlled trial and replacement funding for staff during interviews. LRECs at the time of this research were committed to the review of, and consent for, large medical based randomised controlled trials; therefore any qualitative project was in conflict with this preferred approach. The research design was subsequently challenged by LREC 2 on the grounds that the aims would be better achieved through the incorporation of randomisation, either for selection of the sample, or by undertaking a randomised controlled trial of care. My response focused on the need to understand the concept of privacy through the words and experiences of mothers and midwives so that a theory of privacy could be generated and that this could not be achieved by traditional experimental techniques. Also as the concepts involved in privacy were not yet fully understood, then it was impossible to construct an experiment to assess them. Although this was also debated by LREC 1 the focus there was on incorporating a modified stratified sampling technique to ensure that all grades of midwife were represented in the study. This did not prove problematic as unlike nursing there were only two grades of midwife employed in the maternity unit at the time, so I could reassure them that both grades of midwife would be subject to observation and interview.

Funding for the research came under discussion in relation to expenses for replacement time for staff and indemnity insurance cover for me while in the field. The LREC wanted reassurance that if 15 midwives were interviewed that I would pay replacement salary costs of 15 hours. As I was self funding this would place additional costs on the research of approximately £400; however, I did offer to replace the time myself through my own practice. In relation to indemnity insurance this

was discussed with the research supervisors, my own employer and my professional body (The Royal College of Midwives). My professional indemnity did not provide cover for research activities; however my employer had applicable insurance cover.

Following the interview with LREC 2 it was obvious that the team did not consider grounded theory methodology a suitable approach through which to study privacy. Confirmation that access had been denied came a week later on the grounds that they were unable to release staff from practice to attend for interviews, reflecting the national shortage of midwives at that time. The outcome of LREC 2s decision was received nine weeks before the interview for LREC 1 and highlighted the possibility that LREC 1 may also be experiencing similar problems relating to staff shortages and therefore had the potential to refuse access. In response to the prospect that my research may not proceed it became necessary to search for an alternative sample, should access to hospital sites be denied.

Within my employment I had links with the National Childbirth Trust (NCT), a national charity for the education and support of pregnant and new mothers. The charity works in small groups supporting mothers (and their partners) through antenatal education classes and follow-up support following the birth of their babies. Contact was made with the Head of Policy and Research who confirmed that access would be given on receipt of a research proposal. The proposal for the NCT suggested accessing mothers for interviews at their postnatal reunion class. This proposal was accepted and access granted.

While the proposal was being considered by LREC 1 contact was made with the NCT and a list of course leaders obtained. Letters of introduction were sent to course leaders and telephone contact established. One of the leaders suggested I met with her group during the antenatal period to introduce myself, inform them of the research and secure their participation in the postnatal period. At this first meeting group participants, consisting of 7 mothers and their partners, engaged in a rich and varied discussion relating to privacy. The group were supportive of each other and interactions within the group enhanced the debate, and highlighted the use of focus groups as a possible source of data collection (Gibbs 1997; McDougall 1999).

As I had never facilitated a focus group I decided to undertake a pilot session with a group of student midwives, following approval from my employer. It was not my intention to use them in the study, but more to test my skills in facilitating a group in readiness for focus groups with mothers. However, on completion of the session it was evident that the data added a new dimension to the research identifying a link between their role as mothers (many students were mothers), or novice midwife, and their impending role as a midwife and thus they were included in the research as a third group.

LREC 1 sent confirmation that access to their site had been granted shortly after the first student focus group and meeting with the NCT mothers group. The only condition outlined was the need to destroy the audio tapes on completion of the research. This was confirmed and so access was granted.

The LRECs clearly played a role in restructuring the research and this led to modification of the initial research design.

The Final Research Design

The initial research design included theoretical sampling of mothers and midwives through interviews and observation, whereas within the final design, data were collected through theoretical sampling of mothers via periods of observation, interviews and focus groups. Following a trial focus group student midwives were included in the research with data collected via focus groups and observations (see diagram 1).

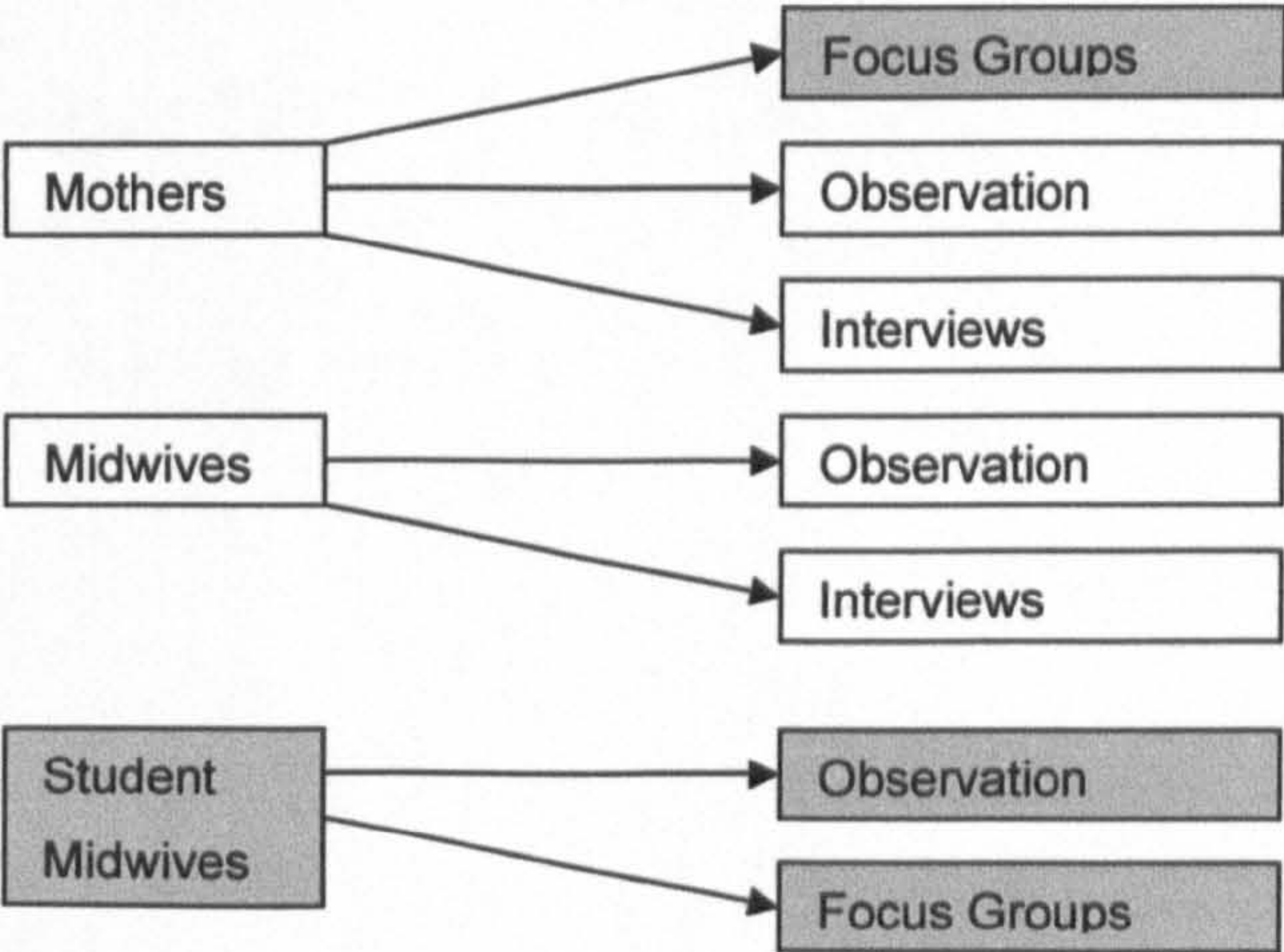


Diagram 1 to show amendments to original research design (new areas shaded)

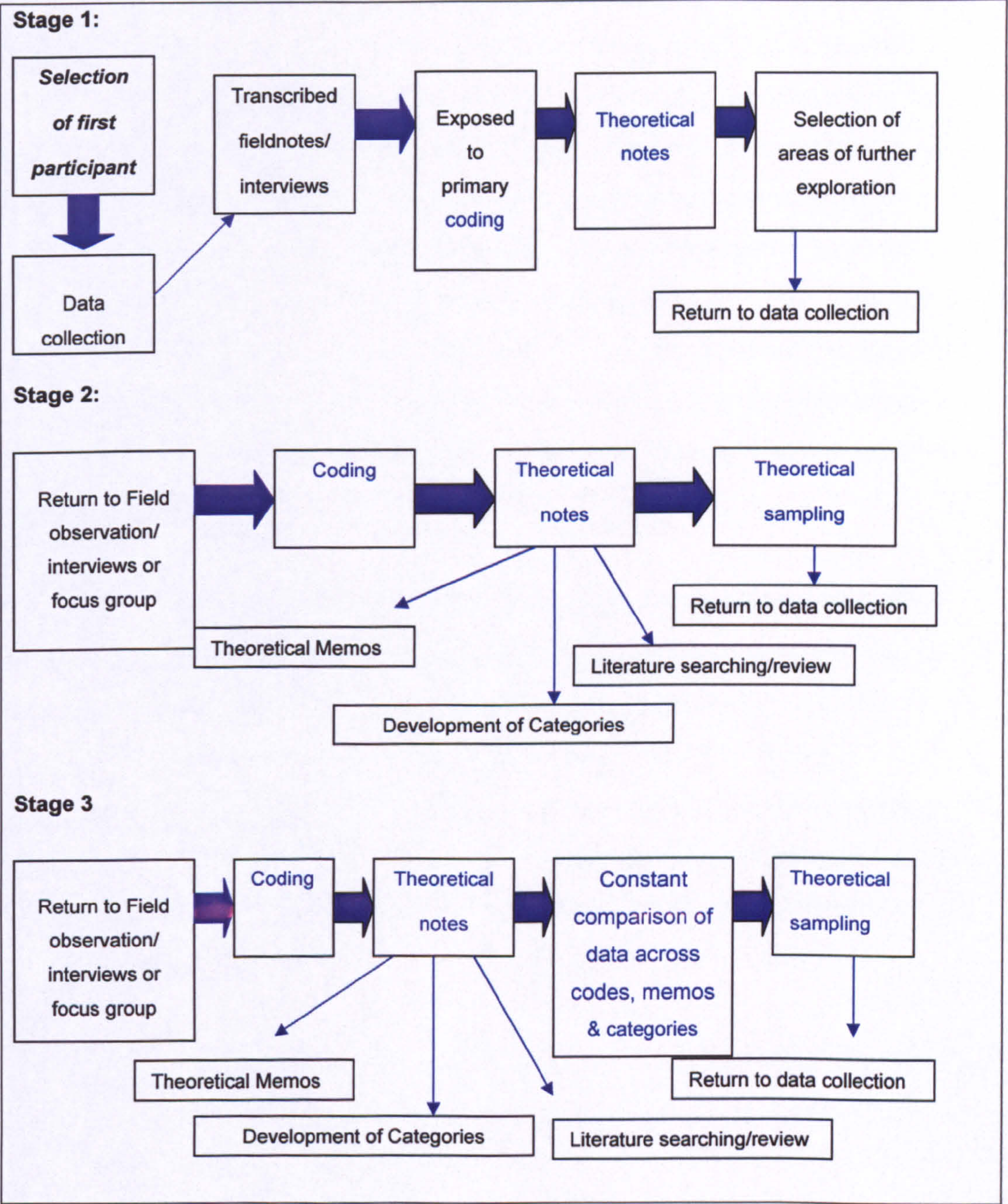
The eventual research design presented challenges for the research linked to exploring three different participant groups through different research methods, within a process of grounded theory. There was a need to consider if each participant group (mothers, midwives and students) should be considered as isolated projects for theoretical sampling and analysis *or* whether theoretical sampling and analysis should occur across *all* participant groups, with the driving force being the concept of privacy. The argument focused on whether to theoretically sample and analyse data to gather a core category for each participant group, in isolation to the others and then compare each at a final stage, as compared to theoretically sampling and analysing data to determine a core category across *all* three participant groups. In practice a mixture of the two approaches was undertaken with field observation as the core element across all three groups. Data collected by this method could then be discussed in the preceding interviews or focus groups, as observation episodes involved interaction of all key participants. As issues arose in one group they could then be discussed and compared within interviews or focus groups, to explore other participants' views, for example if a midwife suggested that mothers wanted a particular type of care this was explored in focus groups or interviews with mothers to determine their perspective.

Data Collection Methods

Data collection methods incorporated within the research included observation, focus groups and interviews. All three methods have been used within grounded theory methodology; however the inclusion of focus groups is a relatively new phenomenon (Donovan 1995). The original aim was to commence the project with participant observation in keeping with grounded theory using this to underpin discussions in interviews and focus groups, however, after meeting with the first group of mothers, and undertaking a pilot focus group with student midwives, this data acted as a foundation for the first observation visit. As the collection process was driven by theoretical sampling and the development of categories, methods were not used in a prescriptive order. It would have been exceptional to say that as theories emerged I was able to enter the field, select participants, discuss concepts and continue analysis in a regimented fashion. In reality there was often a time lapse between the two events with one theoretical lead on hold, while another was explored. In this way all three data collection methods overlapped with each other with data collection points driven by events identified through observations (see Table 2). Within this section

the strengths and weaknesses of each method, the process of data collection and their method of documentation are presented, commencing with focus groups.

Table 2: To show the process of data collection and analysis in grounded theory adopted for this research



Focus groups

Focus groups are a relatively new addition to grounded theory methodology and were used to elicit data from mothers and student midwives (focus groups were not used for midwives as previous

experience of their use, where only small numbers of staff arrived, identified difficulties with participation). Webb and Kevern's (2001) critique of focus groups as a research method suggested they were only used successfully in one instance in nursing research (Donovan 1995), because of the lack of active theoretical sampling. However, there is evidence that they are effective when incorporated into studies early in the research and where they are used in conjunction with theoretical sampling (as in this research) (Donovan 1995; Dey 1999; Gibson and Bamford 2001; McCutcheon and Pincombe 2001; Webb and Kevern 2001; Clark 2004; Coetzee 2004; Heneghan *et al.* 2004). The focus group method provides a forum which helps to ensure the researcher has the scope to collect and analyse data that incorporates opinions, perceptions and understandings of the group, revealed through the interactions of participants (McDougall 1999). An important feature of focus groups is the interaction of group members and how this process enables a full and detailed exploration of concepts to take place. It is argued that focus groups are similar to usual conversations of women and therefore the method is suitable for eliciting data from this group (Madriz 1998).

The inclusion of focus groups occurred following my first visit to mothers from the NCT. At the meeting, which included partners, the group entered into an impromptu discussion on their views of privacy both before and during pregnancy. Mothers debated their perceptions of privacy in relation to pregnancy, while providing both peer support and empathy, reflecting on events using their own words. The mothers confirmed their willingness as a group to meet with me at their postnatal reunion (usually about 6 weeks following birth) but as a group rather than individually, which was agreed. This encounter highlighted the potential for focus groups within the research and resulted in a trial focus group with students.

The function of the focus groups was to achieve a discussion on privacy (Gibbs 1997; McDougall 1999). Participants were chosen because of their exclusivity as a group, their comparable exposure to an environment of maternity care and their commitment to each other within the group. As theories started to emerge contact was made with either the NCT leader or the student midwife set representative and a date and time arranged for the session. Group size was generally kept below 12 to ensure good group interaction (Krueger 1995). It was significant for ensuring participants felt safe and relaxed during the event and so sessions were held in the homes of mothers (or their

leaders) and in classrooms for students (Hoppe and Wells 1995; Madriz 1998). Refreshments were supplied to help create a relaxed and social atmosphere in an attempt to place participants at ease.

I adopted the role of facilitator within the focus group to place participants at ease (Gibbs 1997). It was also necessary to outline the need for confidentiality within the group, how it would be achieved within the research and how important it was that all participants had the right to equal participation and the right to be heard; this was achieved through information sheets given to participants prior to attendance and through a detailed introduction at the start of each group. The literature associated with focus group facilitation recommends that the facilitator has skills in group decision making, organisation and effective communication (Krueger 1995). On reflection it was important for me to adopt a minimalist approach to participation in the sessions and rely on non-verbal prompts and good interpersonal skills (Kitzinger 1994). In this way participants were encouraged to actively debate and explore the issues as they arose with minimal prompting. Mothers were asked to comment on their overall view of privacy during a 'round robin' exercise at the start of each session. This helped to ensure that all participants spoke and felt that they had engaged in the discussion early (Kitzinger 1994; Morgan 1995; Sloan 1998) while also helping to identify participants during transcription, so that interactions could be audited. Participants were encouraged to discuss issues within the group, ask questions, exchange stories, and comment on each other's experiences (Kitzinger 1994). It was this group activity that exploited the communication between individuals and the group, generating substantive data not only on the participants knowledge and experiences, but how and why they thought in that way (Kitzinger 1995). By ensuring that participants reflected upon their experiences focus groups provided a view of the world through participants' own words, descriptions and interpretation of reality (Swenson and Griswold 1992). This interaction and a sense of belonging to the group empowered participants and provided peer support (Goldman 1962; Peters 1993; Sim 1998). The group of NCT mothers and student midwives were discrete groups used to meeting, supporting each other and debating issues within the safety of their group. It is the common bond that the members had towards each other that offered them a feeling of security (Kitzinger 1994). The influence of the supportive environment offered within focus groups enabled participants to explore their feelings, beliefs, experiences, insights and problem-solving strategies through exploration, challenge, clarification, and reformulation (White and Thomson 1995). Group pressure also inhibited

individuals from providing misleading information by enabling responses to be checked with other group members through constant comparison (Sloan 1998).

The first trial focus group was held in a classroom setting with a group of eight students in the third year of a three year midwifery degree programme. On reflection the environment was not conducive with facilitating the session. Students were seated in a circle around the recording equipment but unfortunately the windows were left open and frequent buses passing outside were recorded, thus obscuring part of the conversation. I also took ten minutes to introduce myself and the project before eventually facilitating the session. This initial focus group outlined the need for a focus group schedule (which was subsequently created - see Appendix 2) to provide a clear and concise introduction across groups. It also highlighted the need to be sensitive to the positioning of participants and to the surrounding environment (Sim 1998). Generally the recordings were of a high standard. However, on one occasion in a mothers' focus group a small toddler decided to sing into the microphone, thus obscuring part of the discussion.

Students in the initial focus group engaged in a debate on privacy within care environments highlighting views on both care the mothers received and care offered by midwives. The focus group presented two outcomes, firstly that focus groups if used appropriately had the potential to generate data suitable for theoretical sampling of mothers and secondly, that students had a perception of privacy that was unique in its own right. Students were then selected for inclusion in the study thus creating a third group of participants.

In total eight focus groups were undertaken with student midwives (involving 67 students) and 8 with mothers (involving 43 mothers and 18 fathers) (see table 3). Two additional antenatal focus groups (one being the impromptu initial meeting with mothers) involved both mothers and their partners (7 mothers and 7 fathers in each group). These two groups were undertaken as part of introductory visits to the mothers to promote access to them at their postnatal reunion. Data from the field notes of the first group and audiotape from the second were transcribed and included in the analysis. Although partners were present in the focus groups they offered minimal comments to the discussion leaving most of the debate to occur between mothers. This could have resulted from my introductory speech where I stated that I was interested in the experience of mothers. However,

occasionally fathers did offer an alternate view on events and where this was relevant the extracts have been included in the analysis.

Data collection method	Participants	Group	Participant numbers
Focus groups	Mothers	Group 1 - NCT (plus antenatal discussion)	7 Mothers 7 Men
		Group 2 - NCT (plus antenatal focus group)	7 Mothers 7 Men
		Group 3 – NCT	6 Mothers
		Group 4 – NCT	5 Mothers
		Group 5 – Bumps n Bundles	4 Mothers
		Group 6 – Bumps n Bundles	5 Mothers
		Group 7 – NCT	4 Mothers 4 Men
		Group 8 - NCT	5 Mothers
		Total	8 focus groups 2 antenatal groups 43 women 18 men
	Student Midwives	Group 1 3 year level 1	11
		Group 2 3 year level 1	9
		Group 3 3 year level 2	11
		Group 4 3 year level 3	8
		Group 5 3 year level 1	7
		Group 6 3 year level 1	11
		Group 7 18 month level 3	5
		Group 8 18 month level 2	5
		Total	8 focus groups 67 participants (including 1 male)

Table 3: to show sample characteristics of the focus group sample

Demographic information on participants was collected prior to or during the session. In relation to mothers this included marital status and number of this pregnancy, and for student midwives, demographic information on age, marital status, number of children and year of programme. This information was collected in case it was required at the analytical stage. However, as the aim of grounded theory is not to generalise the findings this information became redundant and was not incorporated into the analysis (Chenitz and Swanson 1986).

Data from focus groups were transcribed and analysed as soon as possible following the event and then subjected to analysis and subsequent theoretical sampling (Strauss and Corbin 1998a).

Although it was proposed to use focus groups for all encounters with mothers two interviews were undertaken, the first in the maternity unit when other members of the focus group did not arrive and the second in the home of a mother as a follow-up visit relating to a period of observation in the maternity unit, which is outlined in the next section.

Observations

Observations are central to the process of grounded theory (Glaser and Strauss 1965; Glaser and Strauss 1967; Strauss and Corbin 1998a) and are used to observe social actions, interactions, behaviour, relationships and events occurring in the research field (McCall and Simmons 1969; Peshkin 2000; Silverman 2004a). The underlying philosophy is that knowledge or understanding of the social world can be gained by observing or participating in the real world and that meaning cannot be generated without observing (Burgess 1984; Mason 2002). Observation and in this case myself as participant observer, enabled data to be gathered through participation in the daily activities of the groups (Savage 2000). The aim was to watch, observe and document participants actions to identify privacy related activities, how they behaved and how the participant interpreted the events or actions (Burgess 1984; Phillips 1996). Within this research the '*real world*' included a range of settings where mothers would have contact with midwives to include GP surgeries, health centres, clinics (both in hospital and the community), delivery suites, wards, homes and specialist units (see Table 4).

Data collection method	Participants observed	Site of data collection (or group)	Participant numbers	Hours in practice
Participant observations	Mothers Midwives Student Midwives	Community practice Trust 1	Varied	105
		Hospital antenatal clinic	Varied	37.5
		Wards	Varied	75
		Delivery suite	Varied	75
		Total		292.5 hours

Table 4 to show participant observation activity

Periods of observation were used to observe mothers, midwives and students, either individually as part of theoretical sampling or generally to observe for further encounters for analysis. It was not possible during these encounters to give a detailed account in relation to demographic information of participants observed because of the sheer volume; however, any personal details collected during the encounter were gathered to add understanding to the event, and not for use during comparative analysis.

Establishing my role in readiness for observation activities was relatively simple once access had been approved. As a researcher it was necessary to acknowledge that I was the instrument of the investigation and therefore the role adopted needed to ensure I was not taking the lead within the setting but remaining passive (Chenitz and Swanson 1986). I chose two different approaches to gaining direct access to clinical areas in order to gain acceptance (Gardener 1997; Ezeh 2003). Firstly, I informed staff that I needed to be updated in community practice as I had not practised

there for some time. Taking the role of updating practitioner enabled me to work directly with a midwife in the role of observer without her confronting my observation and with minimal interaction on my part. Adopting the role of updating practitioner (or novice depending on your viewpoint) gained acceptance with my peers who were keen for me to watch them practice in order to show me their level of expertise. I was introduced to mothers as a midwifery lecturer returning to practice to undertake midwifery research. I worked with three community midwives over a period of three weeks, all of whom had been asked to inform mothers that I would be working with them and to circulate information sheets on my research. Working with community midwives enabled me to ask questions of mothers in relation to their experiences in hospital settings, as compared to their home and with the midwife on return to her car. Field notes were then written in the car and supplemented by audio notes on the actions of the midwife, recorded at the end of each day. None of these midwives or mothers was formally interviewed within the study.

The second approach I used was to inform midwives that I was undertaking a period of professional up-dating in readiness for returning to clinical practice, to collect data for my research. This enabled me to work in all areas in the hospital and enabled me to ask detailed questions of both staff and mothers as I was new to the environment. In this way my roles were constantly negotiated and re-negotiated depending on where observations were taking place (Burgess 1984). Dates of observational visits were organised with senior midwives in the clinical area and I was allocated onto the staff rota, where it was noted that I was supernumerary to requirements, to ensure my practice input was minimal. I was then able to arrive on the day, strategically place my information posters and be allocated to work in a specified area as a midwife. My uniform was different to other staff and this was often used by me as a source of introduction when discussing events and interactions with mothers. In this way I could act as newcomer or novice in the area questioning events and actions. Overall the equivalent of eight weeks (40 days) of observation activities was undertaken (see Table 5).

Place of observation	Total duration of activity	Number of shifts included	No of mothers	No of midwives	No of students
Community practice	3 weeks	15	99	3	0
Hospital antenatal clinic	1 week	5	30	2	0
Antenatal/Postnatal ward	2 weeks	10	Varied	12	4
Delivery suite	2 weeks	10	21	4	6

NB: The interaction with participants did not always result in a data collection episode.

Table 5: To show the place of observation, time allocated and number of participants engaged in interactions

The length of time I remained in the field was subject to a number of influences and often related to current events, the concepts I was exploring and my own concentration levels. The length of observation events varied between the community and the hospital. When in the community setting I accompanied a midwife throughout her shift as it was inappropriate after a short period of observation for her to drive me back to her base. This resulted in some long shifts (8 hours or more) and some shorter shifts (4 hours) depending on workloads. Data were mainly collected during the day with the hospital setting offering a more varied data collection experience because of the number of participants and care environments available. This resulted in observations at a range of times as well as in a range of areas. Overall it was not the length of time in the field that was the issue it was the quality and variety of data collected.

Maintaining an objective stance within grounded theory is linked to developing sensitivity and is necessary to ensure that results are impartial and an accurate interpretation of events. Sensitivity is necessary to explore meanings in data and for recognition of new connections linking concepts. Because of knowledge of the environment and my midwifery experience, it was important to recognise that it would be impossible to remain completely objective throughout data collection and analysis. The method used to promote objectivity was to listen to participants, reflect on events, both during and following observations and interviews, and remain focused when presenting their voice or version of events within data presentation chapters, rather than my own (Strauss and Corbin 1998a; Coffey 1999). Coffey (1999) suggests this can be achieved by reviewing one's position, place and identity within the research to heighten awareness. During the research it was important to review how my own values, cultural background, midwifery training and experience and personal experience differed from that of participants (Cheek 1996). Therefore in the early stages of data collection I reviewed my own philosophy of privacy in order to ensure that I was aware of possible influences on data collection and analysis.

The role of observer has been discussed within research in relation to healthcare practitioners because of the need to remain objective while ensuring the safety of patients as required by statutory duty of care (NMC 2004a; NMC 2004b). The role of participant observer ensured detailed periods of observation while practising as a midwife. In only one instance did my role conflict with my practice and at that time I decided to abandon data collection because of my duty of care to

mothers. Generally I was able to work in the field, observe then withdraw from the setting to document field notes without raising suspicion. In the case of observations all encounters were written into field notes as soon as possible after the event, particularly as it is known that memory deteriorates after 24 hours (Emerson *et al.* 2001). A small pocket note book was taken into the field and used to document data entries. Field notes were written in close proximity to the field and used to describe events, experiences, interactions, people, things seen or heard and conversations, usually in chronological order (Burgess 1984). The data could be phrases, quotes, key words, events and actions of participants and were used to help articulate and understand the world of the participants (Atkinson and Hammersley 1998; Savage 2000; Emerson *et al.* 2001). In most cases the notes were written during withdrawal from the field during breaks or client record keeping. Incorporated into these field notes were primary memos or embryonic theoretical notes which were later incorporated into theoretical memos (see Table 2). Some audio recordings in the form of field notes were also taken when it was easy to carry audio equipment without it being too conspicuous. As data were collected theoretical sampling commenced and the direction of observations became more focused. Data from observations were then explored within interviews and focus groups as part of theoretical sampling.

Interviews

Interviews along with observations are the most common methods used in association with grounded theory, having been included in the methodological design from its inception (Glaser and Strauss 1965; Glaser and Strauss 1968; Glaser and Strauss 1975; Strauss *et al.* 1981; Strauss *et al.* 1982; Corbin and Strauss 1984). Interviews help to construct and reconstruct the knowledge of participants with the understanding that knowledge, views, understanding, interpretations, experiences and interactions are meaningful properties of social reality (Lofland and Lofland 1984). Interviews help to ensure that relevant concepts and emerging theories were discussed so that knowledge could be situated. It was important though to consider an interview as a conversation where the researcher has a goal or purpose and not just an informal chat (McCann and Clark 2005). In this research interviews were undertaken with two mothers and eight midwives (see Table 6).

Data collection method	Participants	Group	Participant numbers
Interviews	Mothers	Trust 1	2
	Midwives	Trust 1	8
		Total	10

Table 6: to show number of interview participants

In grounded theory the research commences with unstructured interviews which become more focused as theories develop (Swanson 1986; Seidman 1998). The aim was for participants to describe their experiences using their own words. McCann and Clark (2005) recommend that participants' descriptions form a narrative that tells a story rather than using structured guidance notes. The story telling narrative helps to ensure that the focus of the discussion remains linked to the participants' perspective (Moyle 2002). Data collections in observation episodes were used as foundations for interviews in order to explore and clarify participants' thoughts and perceptions. An interview schedule or *aide-memoire* was produced in keeping with that identified for the focus groups and included issues relating to the purpose of the interview, confidentiality, format, length and gaining consent (Fontana and Frey 1998; Keats 2000; Miller and Glassner 2004c). It did not include a detailed list of questions to ask until the later stages, when interviews became more semi-structured, as the research became more theoretically focused. This enabled interviews to remain adaptable in tracking the thoughts and ideas of participants, while they narrated their story of events (Morse and Field 1995). All interviews were audio taped and transcribed (Keats 2000).

Eight midwives from a variety of settings were interviewed for a period of approximately 45 minutes (see Table 7). Midwives were selected in two ways, firstly on the day of interview by visiting clinical areas to determine who could be released from their duties and secondly by visiting community midwifery offices and advertising for recruits. Once recruitment had been achieved the aim was to find a setting where there were few distractions and where participants felt relaxed and at ease (McCann and Clark 2005). Three midwife interviews were undertaken in their homes arranged in their lunch breaks. Although these were appropriate environments there was always the pressure of completing the interview during an allotted break. In practice this meant taking a prepared lunch for participants so as to reduce food preparation time, thus increasing the interview time. In the case of mothers, one interview was completed in a consultation room in the hospital, whereas the second was undertaken in her home. This informal environment helped to ensure that interviews were more like an exchange of dialogue than a series of interrogative questions (Keats 2000; Miller and Glassner 2004c). During interviews I remained neutral and encouraged responses through both verbal and non verbal communication, to reduce any influence on the interaction (Seidman 1998).

Table 7: Interviewees area of midwifery practice at time of interview and their professional grade

Interviewee	Area of practice	Professional grade
1	Antenatal clinic/ward	G
2	Delivery suite/wards	F
3	Community	F
4	Community	G
5	Community	F
6	Community	G
7	Delivery suite	G
8	Wards	F

During the process of interviewing I encountered a number of issues that needed consideration. In the first instance securing accommodation within the hospital proved to be problematic but was addressed when a colleague was able to offer a consultation room within the antenatal clinic. This local venue helped to address the second issue which related to the release of staff from practice for attendance for interview. At the time of the research there was a shortage of midwives and interviews were often re-scheduled due to pressures of workload. In one instance I also met with a midwife to undertake an interview to which she gave informed consent. However, the interview was terminated within 25 minutes as a discussion did not emerge and it became difficult to deal with the level of closed answers given. The data collected was minimal and not included in the analysis. Lastly, on reflection it would have been advisable to have returned to interview the participants at a later date in order to further explore theoretical components with them or to clarify some of the data collected (Fontana and Frey 1998).

All field notes, interviews and focus groups were transcribed as close to the event as possible and prior to returning to the field for further data collection episodes.

Analysing the Data

The approach to data analysis adopted for this research involved those associated with the principles of grounded theory (Glaser and Strauss 1967; Strauss 1987; Dey 1993; Dey 1999). These include the use of coding, theoretical notes, theoretical sampling, theoretical memos, constant comparative analysis, development of categories, literature searching, theoretical saturation and striving to develop a final core category (see page 59). This section of the chapter outlines the process of data analysis through the presentation of examples from data. In this way it is possible to present the process used in the journey to a working category. The process adopted

was that suggested by Chenitz and Swanson (1986) as this was found to provide the best working examples.

All field notes, interviews and focus group recordings were transcribed into Word documents in readiness for importation into Atlas.ti, a computer package used to store and facilitate the analysis of data. Atlas.ti was chosen as the qualitative data tool for the management of data early in the project, following a review of possible tools to use including NUDIST, Ethnograph and Atlas.ti. As my place of employment used Atlas.ti the decision to utilise this package was based more on ease of access than requirements of the research (Fielding and Lee 1991; Richards and Richards 1991; Barry 2001). The strength of Atlas.ti however, is that it was originally designed for qualitative data analysis and more specifically grounded theory and therefore the package was flexible enough for and compatible with, those of grounded theory analysis. Atlas.ti enabled data to be managed, extracted, compared and explored in a creative and flexible fashion (Barry 2001).

Transcripts, once imported into Atlas.ti, were subjected to open coding and the construction of subsidiary theoretical notes. Following input of new data previous transcripts were revisited to enable comparison of concepts to take place and axial or substantive coding to occur, in an attempt to secure theoretical saturation (the process is outlined in Table 2). In Stage 1 (as shown on the diagram) data was initially transcribed, primary coded and then conceptual memos (or theoretical notes) made on developing concepts. These embryonic theories highlighted areas for further exploration, in the form of theoretical sampling, through which to focus data collection.

Theoretical sampling commenced early in the study with the selection of groups and sites for inclusion in the research and the data collection methods. Theoretical sampling is described by Strauss and Corbin (1998:201) as:

'Data gathering driven by concepts derived from the evolving theory and based on the concept of 'making comparisons' whose purpose is to go to places, people or events that will maximise opportunities to discover variations among concepts and to densify categories in terms of their properties and dimensions.'

In order to achieve theoretical sampling it was necessary to be theoretically sensitive and aware of the impact of my own personality, experience and prior theoretical insight, on data collection and analysis. As theories started to emerge theoretical sampling became intrinsically linked to methods

of coding (open, axial and selective, see page 59) and to memos. For example, following open coding sampling was broad and open, in order to explore as many issues as possible. As theory development became focused, axial and selective coding became more prominent and so the sampling process became more purposeful, structured and discriminate.

Coding, Theoretical Notes and Memos

Three types of coding are incorporated into grounded theory research, open coding, axial coding and selective coding (Glaser and Strauss 1967; Strauss 1987; Dey 1999). *Open coding* refers to the initial coding used to 'open up' data by systematically coding line by line, the aim of which is the development of concepts or properties within the research. Secondly, and later in the process is *axial coding* or coding associated with one category, the aim of which is to increase density and to explore relationships between categories. Finally there is *selective coding* which relates to coding specifically associated with core categories used to aid further exploration (Glaser and Strauss 1967; Strauss 1987; Strauss and Corbin 1998a). The following example is an extract from an early observation visit to a mixed antenatal and postnatal ward and shows the observation extract and the initial open coding (Table 8).

Table 8: To show an Observation Extract and Open Coding

Observation **	Open Coding
<p>Today I am working in the ward. It is particularly busy today. I was sitting with a mother who was breastfeeding her baby. In the bed next to her was a bay with the curtains drawn. There are 5 other mothers in the ward, 3 in the antenatal period and 3 in the postnatal period. The mother behind the screen could be heard breathing deeply and occasionally crying out. Her cries became more intense as contractions peaked and I felt myself waiting with some trepidation for the next cry. I wonder how the other antenatal mothers feel about listening to this. I asked the mother who I was sitting with what was happening with the mother behind the curtain. She said 'oh she's in labour, poor cow she'll be going down soon' (to delivery suite). The three mothers opposite were sitting on their beds and kept looking towards the curtains. 2 of the mothers were in the antenatal period so I decided to ask them how they felt listening to this mother. The mother in the bed opposite looked very anxious and kept rearranging the contents of her locker. I asked her if she was ok and she told me that she was feeling 'quite sick'. I moved to sit with her and introduced myself. I asked her why she felt sick and if there was anything I could do for her. She looked very nervous. She said no. We started to talk and I asked her about her pregnancy and being in hospital. I asked her about the lady behind the curtain. She told me that she had been like that since they got up at 6 am and no-one seemed to be bothered about her. They (the midwives) had</p>	<p>Ward area Busy</p> <p>Curtains drawn 6 in room</p> <p>overheard breathing deeply, crying out in labour anticipation of pain</p> <p>overhearing someone in pain</p> <p>resigned to pain (been through it)</p> <p>looking anxious</p> <p>overhearing/listening anxious</p> <p>felt sick</p> <p>nervous nothing could do (resigned?)</p> <p>knew about the mother long time no one bothered</p>

<p>given her some Paracetamol but that was 'not a lot of good'. She said that she felt sorry for the mother being in labour in the ward and why didn't they move her to delivery suite. I said it was probably best for her to stay on the ward as she could at least move around. She replied 'what behind the curtains! Would you like anyone to see you like that? (in labour)'. The mother said that she felt sorry for her and that it was frightening the other mothers (but not apparently her although I was not convinced of this). She said it was scary listening to her as she was going to have to go through that in a few days.</p>	<p>pain relief insufficient empathy</p> <p>not right place to labour (on ward)</p> <p>confined not wanting to be seen</p> <p>empathy frightening others scary overhearing speculation of impending pain</p>
--	---

The episode was detailed in my field notes, transcribed and analysed. The aim of the analysis was to take the extract apart and review data fact by fact and incident by incident, while observing for issues relating to privacy. The next stage of the analytical process was to review the transcript and document ideas and questions emerging from data, in the form of theoretical notes (see example in Table 9 below). Theoretical notes are questions posed by data which maybe worthy of further exploration through theoretical sampling at the next data collection episode.

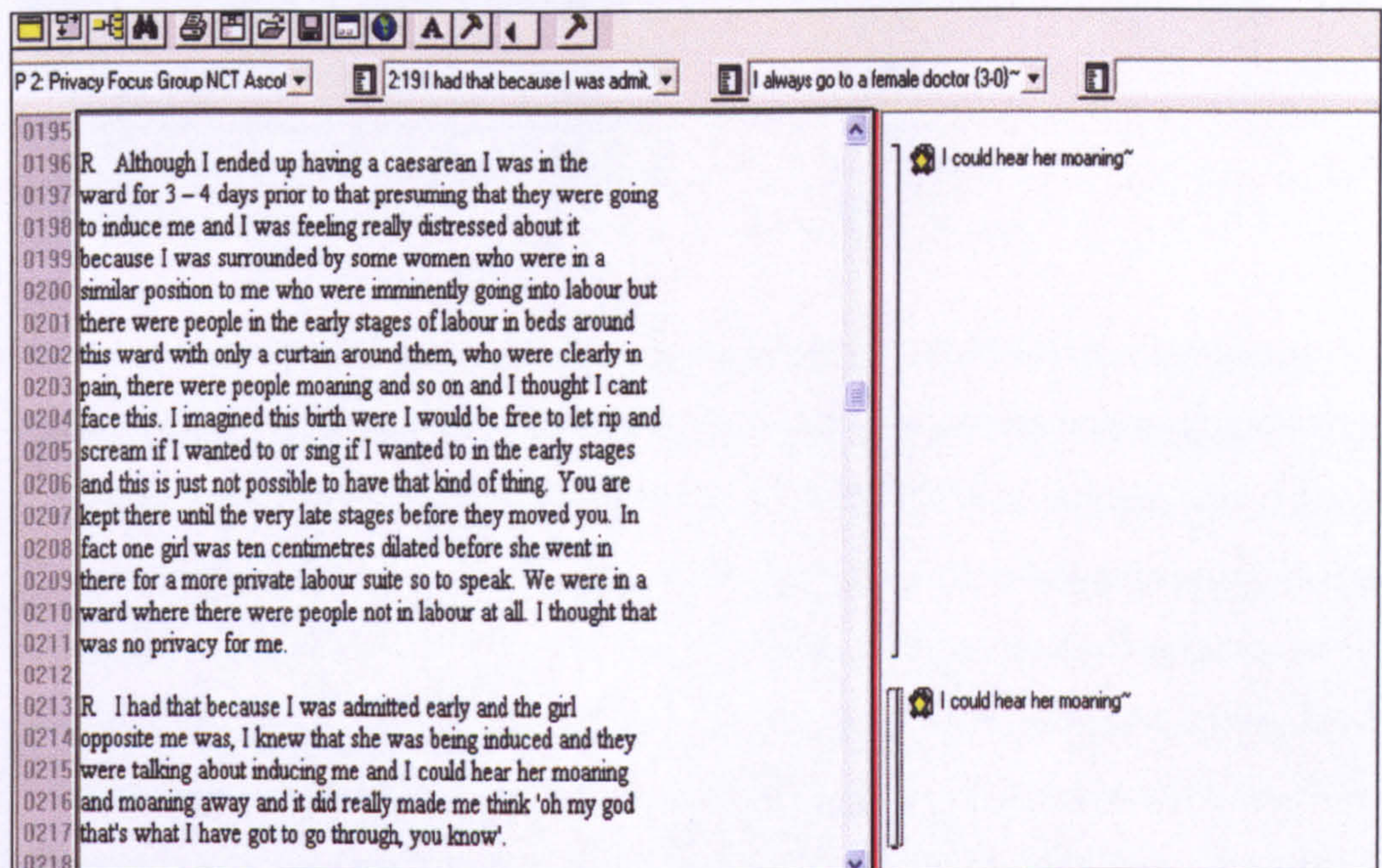
Table 9: to show open coding and extract from the theoretical notes

Fact or incident	Open Coding	Theoretical Note
In hospital Area perceived as busy	Ward area Busy	Does this incident only occur in the ward environment? Could the area be perceived as busy due to overcrowding?
Curtains drawn	Curtains drawn	Are mothers frightened because they can't see what is happening to that mother? Is the mother ok does she feel the same? What does the mother feel like behind the curtains?
6 mothers in room	6 in room	I wonder what impact the number of people in the ward would have on the mothers' view of privacy. I will need to follow this up in the field.
can overhear	overheard	The impact of overhearing some one in pain appears to increase anxiety, makes the mother nervous and frightens her. I wonder if this is the same for all mothers or just new ones.
mothers in labour	Crying out	This suggests that labour is bad as it causes pain to the point where the mother is crying. Are all mothers like this?
anxious about pain	anticipation of pain	This is linked to not being able to see the mother. Is it that if you can't see the mother then how do you know that she is coping? This in turn increases your anticipation of your own pain? Is there an anxiety here that we are listening to that mother at a very personal time and what right do we have to intrude?

The process is time consuming and laborious but resulted in detailed information on the processes and behaviours of participants. Theoretical notes are eventually merged into theoretical memos or a *theory in preparation* (Glaser and Strauss 1967; Chenitz and Swanson 1986; Strauss and Corbin 1998a; Dey 1999).

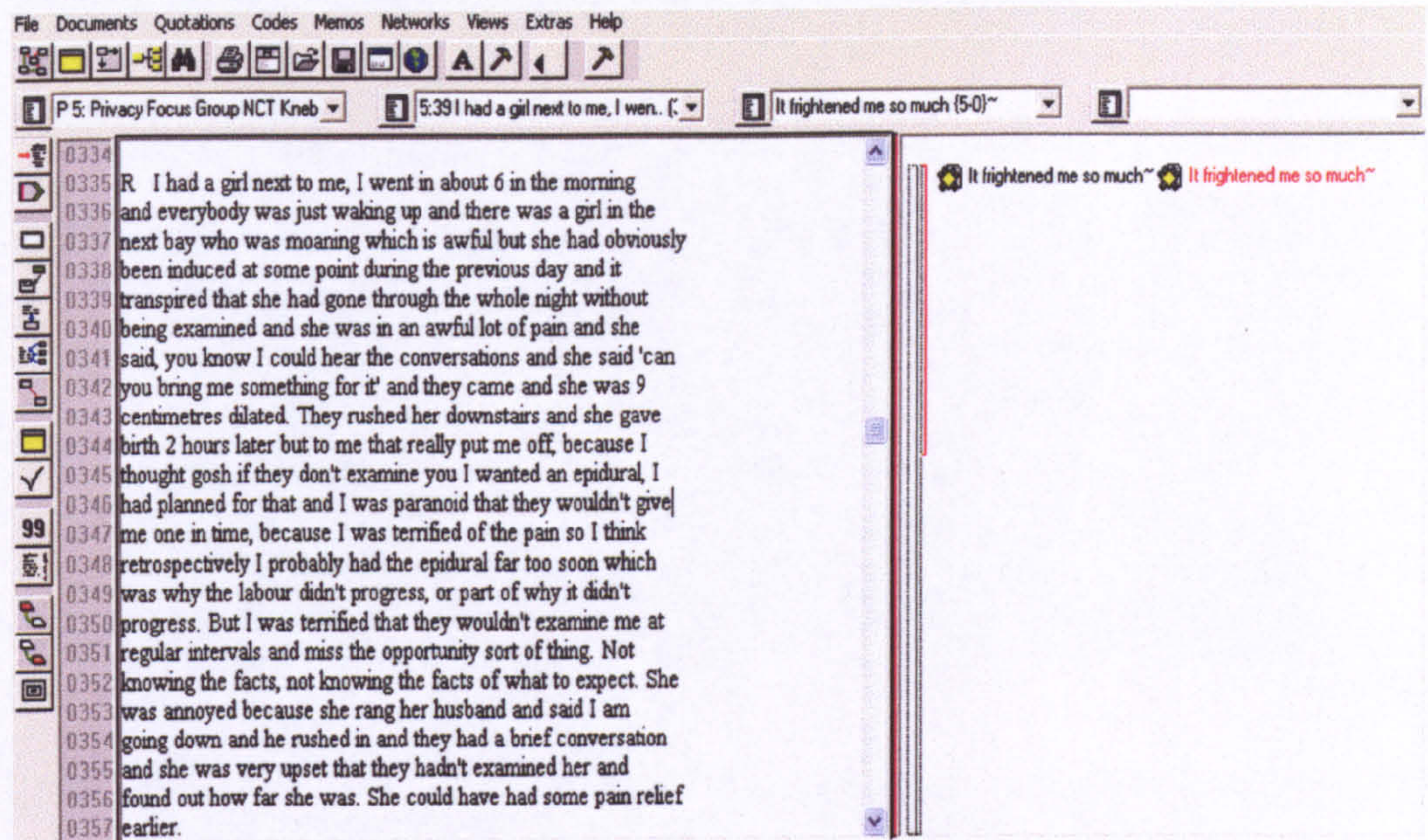
Following this example observation episode, the next stage was to explore the notion of overhearing others in pain with mothers, during focus groups and interviews, through theoretical sampling and subsequent axial coding (see diagram 2).

Diagram 2: Extract from Atlas.ti to show axial coding of mothers in pain



Within focus groups the discussion centred on the outcome of overhearing others and its effect on mothers' ability to cope during their own labour. As the need to explore the outcome of overhearing became more specific, direct questions were asked of mothers in relation to how they felt after overhearing others in pain (see diagram 3).

Diagram 3: Extract from Atlas.ti to show selective coding for mothers in pain



As coding became more specific, memo production became more theoretical and linked to supporting literature. Memos were written to document ideas and concepts emerging from data and developed an account of the analytical process, being initially linked to open and axial coding as theoretical notes, and then, as they expanded in depth, to selective coding and theoretical memos (see diagram 4 below). Memos act as a repository of information on ideas and questions asked of, and generated from, the research, the analysis of comparisons within data and modifications or changes undertaken. Memo keeping is a tedious and time consuming exercise but is crucial to the analytical process (Glaser and Strauss 1967; Chenitz and Swanson 1986; Strauss and Corbin 1998a; Dey 1999). As the research progresses they became more detailed and integrated and included additional sources of literature as evidence to support theory generation. Theoretical notes were documented within Atlas.ti and linked to the method of open coding, whereas theoretical memos were typed as Word documents, and added to and expanded upon, depending on the theory being considered. Each memo was dated, titled, cross referenced and filed for ease of retrieval (Chenitz and Swanson 1986).

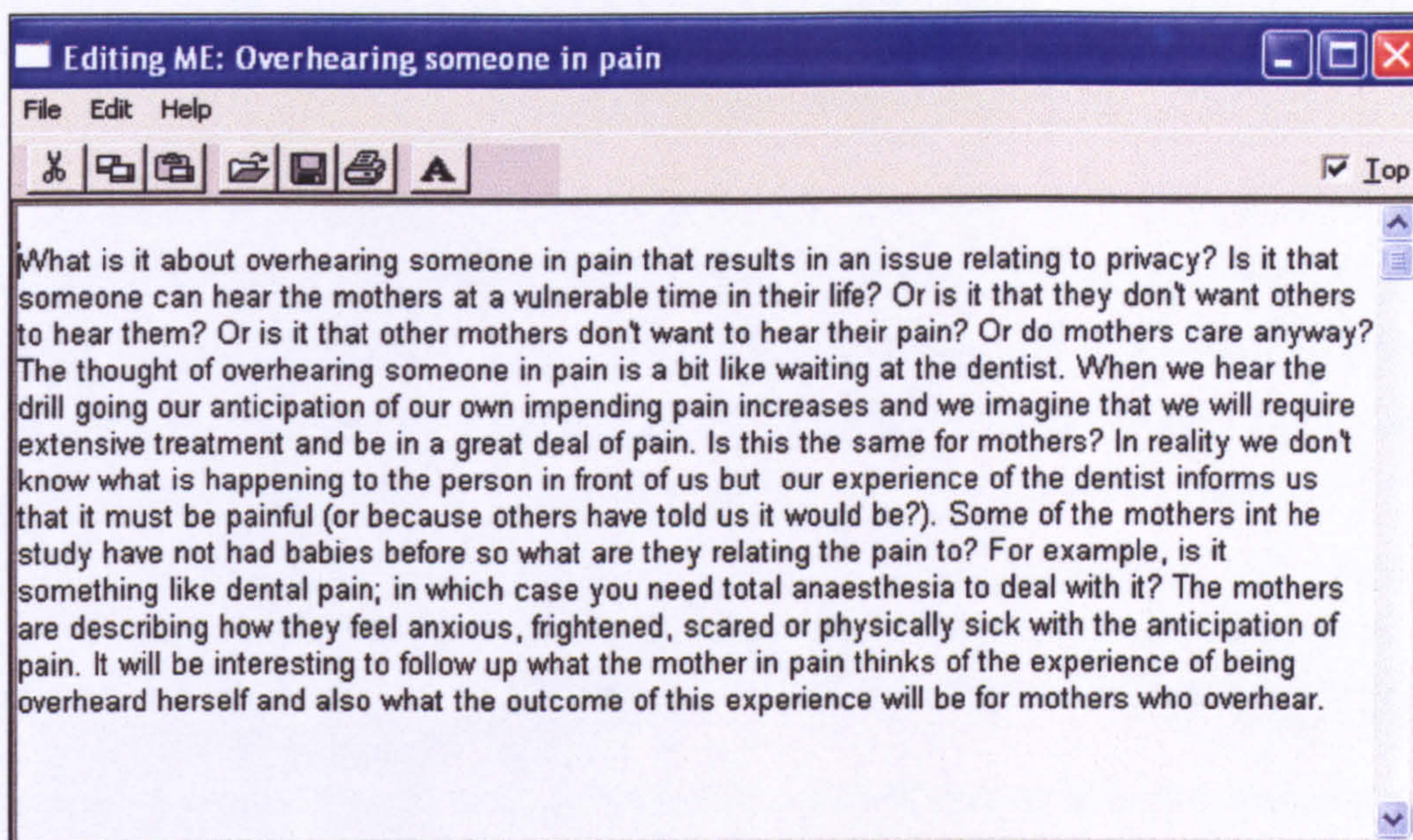


Diagram 4: to show Extract from the theoretical memo 'Overhearing someone in pain'

Each data episode was collated, analysed and compared against other similar events to see if the actions and behaviours of participants varied or were consistent. The constant comparative method refers to the process of comparing incident to incident at the '*property or dimensional level*' (Strauss and Corbin 1998a:79) in order to determine similarities and differences within data. The first aim of the process is to classify data into concepts or categories with the final aim of enhancing theory development.

Once an early theory was proposed then the decision was made to undertake a focus group, interview or period of observation, whichever was deemed suitable to explore the developing theory. In Stage 2 (page 47) data was collected as usual, transcribed and coded. However, at the stage of making theoretical notes, memos started to emerge as an accumulation of notes and ideas. As theories started to emerge a literature search around the topic was also undertaken to explore the possibility of supporting evidence within memos. As codes became more numerous they were classified into categories or sub-categories to provide explanations of the processes or behaviours under exploration, until theoretical saturation occurred and no new codes or categories were occurring.

The development of categories

As the coding process extended codes started to emerge in relation to phenomena observed in data. As codes emerged from data they were collated into concepts or properties (Glaser and Strauss 1967; Strauss and Corbin 1998a; Dey 1999). These concepts were then grouped together based on their potential to explain the overall phenomena. In the definition of categories offered by Strauss and Corbin (1998a:113) they suggest that '*categories have analytic power because they have potential to explain and predict*'. They continued:

'Categories are concepts, derived from data, that stand for phenomena.... Phenomena are important analytic ideas that emerge from our data. They answer the question 'what is going on here?' They depict the problems, issues, concerns and matters that are important to those being studied.'

Codes therefore were placed into a hierarchy which consisted of codes, concepts, sub-categories and categories all of which play a role in helping to define the phenomena under scrutiny (Glaser and Strauss 1967). At one stage I constructed four categories auditory, visual, physical and environmental that appeared to incorporate the concepts involved. In practice these were too broad and did not enhance theory development and so they were subsequently replaced by categories that were more grounded in the developing theories. In Diagram 5 below the codes relating to 'overhearing' are shown in a sub-category called '*People moaning- overhearing others in pain*'.

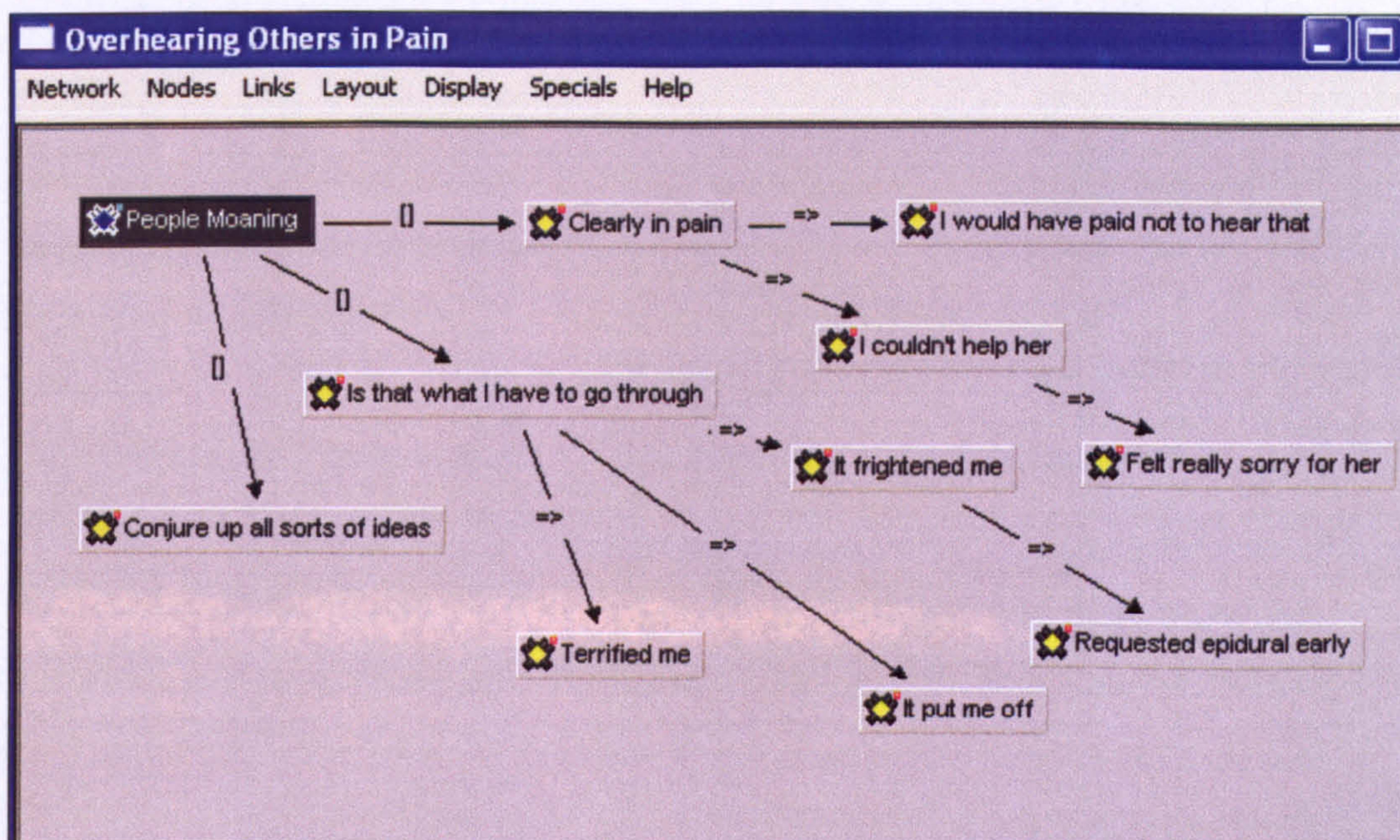


Diagram 5: To show preliminary concept map for People Moaning – overhearing others in pain (mothers)

This initial concept map constructed through Atlas.ti documents the consequences of overhearing someone in pain without seeing what they are experiencing. Mothers described their feelings on hearing this event as empathy, hopelessness, stress, fear and terror, the outcome of which was a request for early pain relief, in some cases even before pain commenced. The process outlined above was completed for each of the three data sets, mothers, midwives and student midwives, resulting in a number of categories and sub-categories with similarities across all three groups.

Four categories were created from mothers' data, *Personal Privacy: withdrawal and solitude*, *Eavesdropping and Disclosure Privacy*, *Objectification of the Body and its Effect on Privacy* and *Privacy in a Public Environment* and presented within three themes within chapter 4. These categories related to mothers' privacy in relation to the body, personal information and the environment during the process of having a baby. *Personal Privacy* outlines how mothers attempt to withdraw from social interactions to ensure privacy from others on admission to wards. *Eavesdropping and Disclosure Privacy* relates to disclosure of personal and bodily information either through being heard, overheard or revealed through documentation. *Objectification of the Body and its Effect on Privacy* describes how mothers in retrospect perceive themselves as shy, and how they are subjected to increasing levels of bodily exposure during antenatal examinations, resulting in desensitisation, compliance and finally objectification of the body. The category '*Privacy in a public environment*' outlines how being in a communal environment is influenced by a range of social etiquettes and attitudes of staff and mothers' need for personal accommodation. Each category consisted of a number of questions constructed and explored through data and the process of theoretical memos.

Four categories from midwives data are presented as themes within Chapter 5 namely, '*Privacy of the Body*', '*The Environment of Care*', '*Discussing Mothers' Personal Information*' and '*Midwives Perceptions of Self Privacy*'. The first three categories derived from midwives' perceptions of mothers' privacy needs as *perceived* by midwives. The first titled *Privacy of the Body* describes midwives' perceptions of privacy in relation to mothers' physical privacy and exposure of the body, exploring issues such as, physical examinations, being covered, trust and touch. The second category explores *The Environment of Care* in which midwives work dealing with data relating to midwives' views of mothers' personal space, visitors, accommodation, access to rooms, and their

duty of care to observe mothers. The third category *Discussing Mothers' Personal Information* includes information on access to records, professional rights to discussion, disclosure of information and discussions during physical examinations. The final category explores *Midwives' Perceptions of Self Privacy* to identify how their own perceptions of privacy impacted on their interpretation of the privacy needs of mothers. While the majority of data were linked to midwives' personal ideals, discussions inevitably returned to the impact of their privacy expectations on their duty of care to mothers.

Three categories are presented from the students' data within Chapter 6, *Women with their bits and bobs everywhere*, presenting data relating to students' perceptions of what influences the privacy of mothers and their interpretation of how mothers feel and act in relation to being exposed, viewed or photographed, having people present during intimate procedures and dealing with body fluids or functions. The second category, *Environment of Care* describes how the setting influences care mothers receive and includes discussions on data relating to: access to facilities, knocking on doors and a person's right to entry, overhearing conversations or talk, being viewed by visitors and students' perceived differences between having a baby at home as compared to hospital. The final category, *The role of the professional in protecting the privacy of mothers*, outlines data on students' views on their role as helper or advocate, the impact of workloads, and general issues relating to their role.

To show how categories developed the following is an example of one category from mothers' data:

Category 1: The Hunt for Personal Privacy: withdrawal and solitude

Questions were posed during data collection and theoretical sampling that eventually become the foundation for theoretical memos. The question constructed from data and then explored through theoretical memos for this category was:

'How do mothers achieve, promote and maintain privacy through withdrawal and solitude within both wards and delivery suites?

The sub-categories for this category are shown in diagram 6 below:

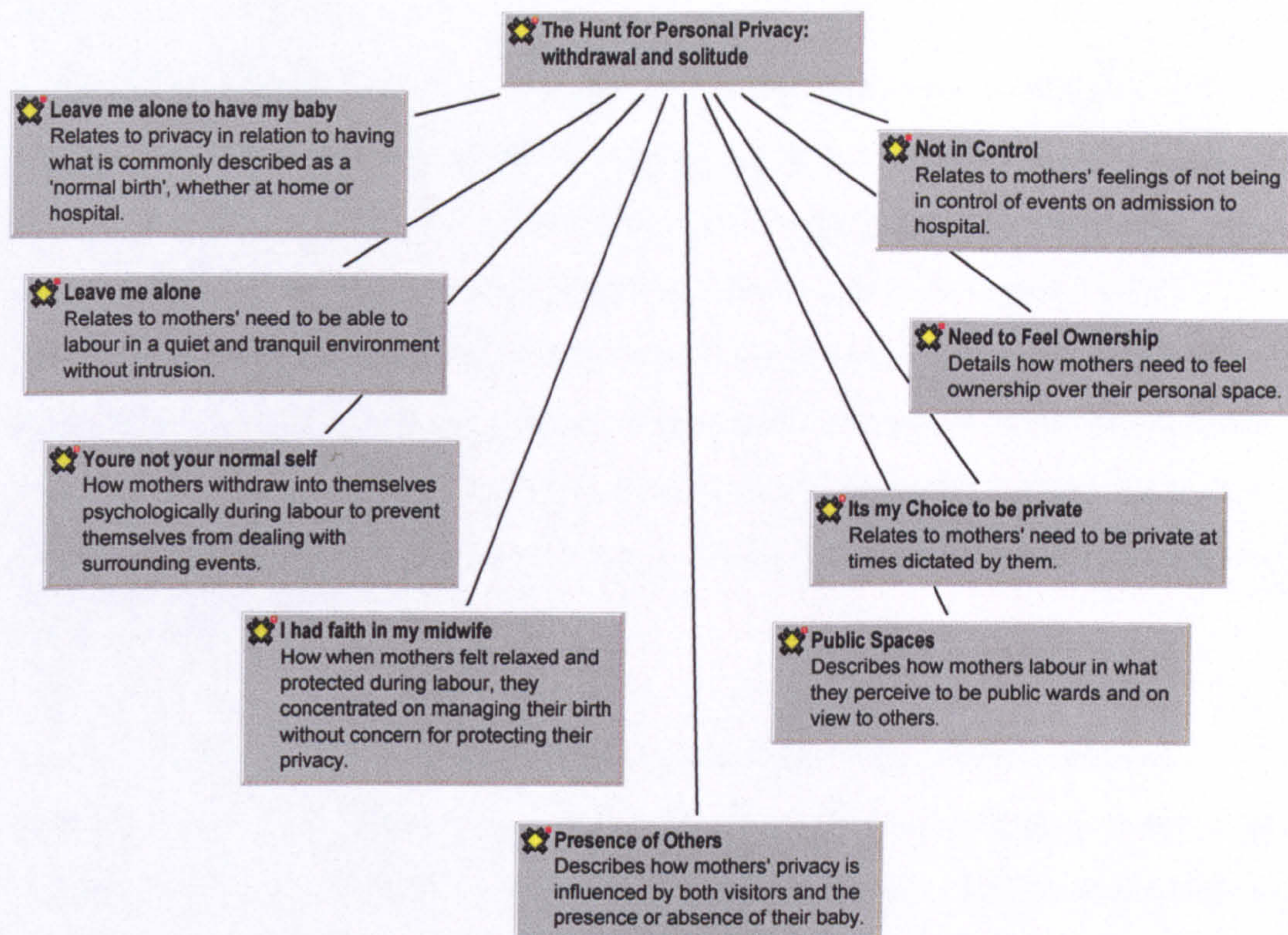


Diagram 6: To show the sub-categories within the category The Hunt for Personal Privacy: withdrawal and solitude.

During the writing stage this category was combined with Privacy in a Public Environment and presented as the theme 'Privacy in a Public Environment'.

During data collection, analysis and construction of categories it was important to ensure the accuracy and reliability of the research.

Ensuring Reliability and Accuracy within the Research

To ensure accuracy and reliability of the research, questions must be asked both of the research design and presentation of data. The goal is to provide research which is thorough, careful, honest and accurate so as not to invent or misinterpret data (Mason 2002), or as Charmaz (2006) states research which has credibility, originality, resonance and usefulness. As shown below this can be achieved by ensuring validity of data generation methods, validity and reliability of interpretation and analysis (Strauss and Corbin 1998a; Mason 2002), respondent validation (Barbour 2001), presentation of negative or deviant cases (Mays and Pope 1995), minimising researcher bias (Mays and Pope 1995) and the provision of supporting literature (although this should not direct the research).

The criteria for evaluating any grounded theory project should include judgements on validity, reliability, credibility of data, judgements about theory, adequacy of the research process and empirical grounding. While determining the validity of the research the search is not for generalisation but '*explanatory power*' or the '*ability to explain what might happen in given situations*' (Strauss and Corbin 1998a:267). What is sought from data are conditions giving rise to certain phenomena and their consequences, to gain multiple viewpoints on situations and enable participants to speak through the research (Strauss and Corbin 1998a). The aim is not to seek a general or grand theory but a substantive theory, which has developmental potential (Strauss and Corbin 1998a).

Validity within the research is enhanced through the use of theoretical sampling, constant comparison and reflexivity during data collection and analysis. Theoretical sampling (a form of non-probability sampling) is used to guide the process of sampling and data collection so it is iterative and theoretically-led (Glaser and Strauss 1967; Mays and Pope 1995). The strength of data collected by theoretical sampling is dependent on methods adopted and validation of data generated. The use of the term multiple methods is preferred to triangulation in grounded theory; here multiple methods are adopted to obtain '*the varied meaning and interpretation of events, actions/interactions and objects so that we can build variations into our theory*' (Strauss and Corbin 1998a:44). On reflection the use of focus groups, participant observation and interviews illuminated the concepts of privacy, giving mothers both the chance to discuss concepts from their own perspectives while I explored them further through observation, questioning (to ensure clarification of concepts) and visualisation of interactions (Strauss and Corbin 1998b).

In relation to research design the parameters were influenced by requirements of the LRECs and so measures had to be put in place to meet the potential loss of access to NHS Trust sites. This meant that participants had to be sought outside of the NHS and although the intention was to undertake interviews with mothers, it became evident that focus groups were close to their natural grouping and would facilitate a wealth of data. The social dynamics within focus groups, where mothers and students were able to communicate effectively because of their existing group bond, promoted debate and exploration of issues. Although the interaction between participants in focus groups is important this is not discussed in the following chapters as the research is concerned with

theory development. Although demographics were collected from students and mothers these were also not used in the data analysis as they were not deemed relevant to a process which is data and theory driven, unless they were relevant to the story being told.

Validity in interpretation and analysis can be traced through the documented research process as shown in the examples given within this chapter. Each stage of the research was systematically documented and collated within Atlas.ti for easy retrieval, cross analysis and re-analysis, where required, to retest reliability (Mays and Pope 1995). Although audiotapes will not be available for retesting this could be undertaken through review of transcripts.

Current debates on respondent validation argue for transcripts to be returned to participants for review and clarification (Atkinson 1997; Barbour 2001) however it is also argued that this results in research driven from individual concerns or motives, rather than from participants in general (Mays and Pope 1995). Barbour argues that returning transcripts can be time consuming and open participants to exploitation or distress, or as Atkinson suggests it romanticises respondents' accounts. Return of transcripts was not undertaken within this research because of the large number of participants and their varied geographical location.

Minimal deviant cases were evident within the research and are presented within data Chapters 4-6, to show the explanatory process and how and why they varied from the norm. When collecting data it was also necessary to ensure data was not based on secondary stories or hearsay (Mays and Pope 1995) and although examples of these were given in focus groups these were not included within the analysis.

Researcher bias can enter the research through data collection and analysis and in relation to this research, through my personal role as midwife in the research setting. In the early stages of data collection it was necessary to remain focused on studying issues relating to the project and not become side tracked. As the research progressed and became more focused it was necessary to follow-up only selective codes and not just those of interest to me as a midwife. During participant observation in wards, participants became used to my presence reducing my impact on the setting; however when working in the community or delivery suite with a specific midwife the impact of the role of participant observer was difficult to measure. Using a range of environments helped to

ensure I witnessed the full range of conditions in which mothers found themselves, while focusing on typical behaviours across a range of times and events. In order to reduce researcher bias it was important to present data from the perspective of participants, while remaining true to the data. In order to achieve this 'best' extracts have been taken from data as key examples.

To ensure validity of the research the research has to be credible, that is, reviewers can determine how I came to my conclusions (Glaser and Strauss 1967). This was achieved through multiple comparisons of groups, showing similarities and differences between data and its applicability to the substantive theory. In practice this is interpreted as the concept of privacy being relevant to the area in which it is to be applied, being understood by its target audience and applicable to a range of daily situations.

Conclusion

In conclusion, grounded theory was selected because of its strength in portraying the words and actions of participants with the aim of working towards the development of a practical guide on privacy which could be incorporated into everyday practice or policy development. As is shown in the following chapters it enabled an in-depth exploration of privacy in relation to mothers, both from their own perspective, but also from the perspective of student midwives and midwives.

While the initial research design proposed data collection from mothers and midwives, through interviews and participant observation, the research had to be modified when it looked as if the project would not proceed through the LREC. At that point a decision was made to select a different population of mothers, outside of the hospital setting, in case approval was rejected. What resulted was access to a larger population of mothers, already in discrete groups, which lent itself to focus groups rather than individual interviews. In practice this resulted in greater discussion within the group and a wider breadth of data. The inclusion of student midwives, while not connected to LREC approval, resulted in the addition of a further data source which was unique in its own right. As you will see students brought to the study not only their own personal experiences as women and mothers, but also their experiences of practising within a midwifery setting, creating an observation bridge between both mothers and midwives.

Data collection methods used within the research included focus groups, interviews and field observations. While field observations and interviews are commonly associated with grounded theory, the inclusion of focus groups as a method is relatively new. Inclusion of focus groups resulted in detailed and enriched data relating to privacy, from established groups of mothers and students who were used to debating issues relating to pregnancy and childbirth. Managing theoretical sampling with this method appeared no different to that of interviews, with ideas and concepts being addressed within subsequent groups.

As data emerged through theoretical sampling, concepts were developed first into opening codes, then concepts, sub-categories and eventually categories, with the final write up presented as themes (Kitzinger and Barbour 1999; Webb and Kevern 2001). In the three chapters which follow the stories of privacy in maternity care environments are presented from the perspectives of, mothers, midwives and student midwives.

Chapter 4: Mothers' Perceptions of Privacy

The previous chapter described the process of data collection from mothers, midwives and students through observations, focus groups and interviews. This chapter presents data from mothers with a view to understanding what privacy meant to them in relation to pregnancy and childbirth. In order to explore the original research aims it became evident that it was necessary to explore whether privacy was actually important to mothers and if so, what concepts were involved. For example, at a time when mothers are moving through a major life experience, are they actually concerned about their privacy? Do concepts of privacy vary during pregnancy and childbirth and how do mothers cope with privacy at each stage of pregnancy? Does exposure of their body impact on their perceptions of privacy and how far is privacy influenced by the environment of care, or the practice of midwives and other healthcare practitioners? In order to address these issues this chapter is subdivided into three sections: the first explores whether and how mothers attempt to achieve privacy within busy and overcrowded wards; the second section relates to 'eavesdropping' and explores how sharing of personal information impacts on their privacy and the final section considers the role of bodily exposure on mothers' ability to secure and maintain privacy. The analysis suggests that thinking about privacy is not fixed, rather it is influenced by the stages of pregnancy, the context, and the environment in which mothers find themselves. What we will see is that mothers do not want to be seen by others as incompetent or unable to cope, particularly when in pain during labour or during bodily exposure. Privacy for mothers therefore is an important measure linked to ensuring they appear competent in all aspects of being a new mother, throughout pregnancy and childbirth.

Focus group members often commenced their privacy stories by reviewing their attitudes towards privacy pre-pregnancy, portraying themselves as '*private in mind and body*' and privacy '*shy*'. For example, at one pre-focus group recruitment meeting mothers within the group highlighted their early reservations regarding bodily exposure, particularly as most had never had a vaginal examination or smear before becoming pregnant. With this in mind, mothers within focus groups were able to reflect upon their understanding of privacy prior to pregnancy and relate it to their experiences of privacy both during pregnancy and the puerperium:

'I think that privacy, before I had the baby, I didn't realise it but I was quite a private person..... Looking back I think, knowing now how private I was, how did I get through that whole experience?'

(FG4)

'You go into it (pregnancy) thinking I don't want to show myself at all and I don't really want too many people in the room. I am quite shy and what have you.'

(FG 3)

Mothers within focus groups described how they had assumed they would be able to retain control over actions and interactions with others throughout pregnancy, maintaining their pre-pregnancy privacy status. As will be shown, they outlined how in practice they quickly adapted to hospital routines and professional expectations, with adaptation being on their part, rather than the system responding to their individual requirements. So what did mothers find when they entered the maternity services and how did this affect their privacy status? What we need to consider is that maternity hospital environments are not natural environments for mothers and however homely hospital designers try to make this setting, it does not mimic normal social conditions. This next section explores a major theme in most of the focus groups that of the reality of admission to hospital for mothers within the study.

Privacy within a Public Environment

Mothers within the study described their experiences during admission to a hospital ward or delivery suite during their pregnancy, or following commencement of childbirth, after community based antenatal care (only two mothers in the study had their baby at home). In today's society in the UK 98% of babies are born in hospital (ONS 2006) with mothers admitted either to a ward or to a transitional area within a delivery suite (when in early labour). Admission occurs in one of two ways: to a single room in the delivery suite when mothers are in *established* labour or to wards following the presence of obstetric complications or passive labour (where labour has the potential to cease). Mothers within focus groups admitted to hospital under these circumstances found themselves in antenatal wards with other mothers who were not necessarily in labour, or in delivery suite transition rooms where they were encouraged to use communal sitting rooms in which to labour. On admission to ward environments mothers in the study thus found themselves in unfamiliar territory having to adapt to communal living, surrounded by strangers, being exposed to other residents' family and friends during visiting, and dealing with the presence of staff.

On admission to wards one of the first challenges facing mothers seems to be the acquisition of personal privacy. Having been allocated a bed and staked a claim on this allocated temporary accommodation, mothers in both focus groups and interviews reviewed their privacy in relation to the environment. For example, did they need to wear their own clothes? Should they get into their nightie? Were they able to control access by other mothers? Could they control access to the environment by others, such as visitors? Once they were aware of their expected behaviour in the setting they set about securing their place within it.

Maintaining an identity within a public environment appeared to be linked to the acquisition of personal space in which to unpack personal belongings, and in relation to new mothers, creation of space into which to bring their babies. It seemed that it was not necessarily ownership of the environment nor the concept of personal space that was important to mothers, but ownership of items *within* the space (Rossler 2005); what mothers described as '*being surrounded by your own things*'. Being surrounded by personal possessions, mothers within the study suggested, enabled them to keep their own space private, even though within unfamiliar surroundings, thus helping to increase their sense of autonomy.

'I wanted to have my own things with me, my own stuff, to make me feel at home, things that I needed that were mine, ...to let others know that this was my space.'

(FG 2)

Unpacking their belongings appeared to enable mothers within the study to show a legitimate right of presence in wards and prevented other mothers from accessing their space. It has been shown that if residents identify with their temporary surroundings they considered them to be an extension of themselves (Levinas 1969) or a 'mirror' of their personal space at home, thus promoting a sense of security within the setting (Gramaccini 1998).

Today's hospital wards no longer have communal living spaces such as dining rooms and sitting rooms, as they are not considered good use of space following reduction in the duration of admission and the need for high bed occupancy. This means that allocated bed space has become a place where mothers eat, sleep and entertain guests. On admission to most maternity wards in this country mothers are accommodated in a room of 4 - 6 beds with shared toilet facilities.

The number of occupants in rooms and size of accommodation were identified by mothers in focus groups as influential to their procurement or reduction of privacy and their ability to selectively acquire privacy when desired:

'They were 4 – 6 bedded bays. So you had people around so it reduced the incidence of having privacy, you just didn't get any.'

(FG 1)

'My sister in law had her baby in London and their wards only have two beds in them and they have an en-suite sort of bathroom and so you don't have too many people and she had the room to herself and that was brilliant. That would have been ideal.'

(FG5)

Although mothers were aware before admission that facilities were multi-occupancy, in reality it seemed from their discussions in focus groups that the impact of this on their pregnancy was not acknowledged until they reflected upon their experience retrospectively. One recommendation made by mothers within the study was that future ward designs were structured so as to address mothers' privacy needs by providing single occupancy rooms.

The skills required by mothers to function within this multi-occupancy environment were in addition to existing changes already taking place as they adapted to the birth process and becoming new mothers. Within this environment of change mothers found themselves needing to readdress or abandon their privacy needs and expectations in order to meet their personal and their baby's requirements while considering those around them:

'I was admitted at 11 o'clock and settled down and then suddenly a woman came up from the labour ward with the midwife and she was snorting and grunting and trying to get herself organised and so it was another hour and a half or so before she finally nods off, but she left her light on and all this sort of stuff and so I still didn't get any sleep.'

(FG5)

'There was one woman whose baby, wouldn't suck and she was getting really agitated about it and the baby was getting really frustrated with it, being hungry and everything and oh, my god, they had everybody and their mothers coming in to discuss around the bedside at 4 o'clock in the morning, their theory as to why he wouldn't suck and why he was crying. It was really annoying they weren't even whispering they were talking at the tops of their voices as if it was in the middle of the day and that I found really frustrating.'

(FG 3)

Behaviour such as these by others influenced mothers' ability to ensure their personal space was not breached by noise or intrusion. Reducing the amount of sleep received mothers perceived as increasing their intolerance of both cohabiters and staff (Proshansky *et al.* 1970; Steiner 1970). The

most problematic behaviours associated with privacy in wards, mothers argued, were the sleeping habits of others, and in particular snoring or leaving lights on, which resulted in them being unable to sleep or secure their own space in order to rest.

Intolerance of other residents was highlighted by mothers' in multiple occupancy rooms. During observations, some mothers within the study expressed their lack of tolerance of their peers, conveying a distinct dislike of sharing space with strangers. One mother stated:

'There is quite a mix of people in there that makes you aware as well. There are certain categories I wouldn't go into a bar if they were in. I certainly wouldn't want to share a room. ...I didn't want to talk to anyone actually, these are not people that I would choose to socialise with out of hospital.'

(Jessica Interview 1)

Mothers in focus groups tended to agree that communal rooms resulted in them having to interact with other mothers even when they had no affinity with them. They felt there was insufficient time to develop relationships with others mothers during admission and so intolerance of individual characteristics increased. Mothers were generally not interested in developing friendships with others as they were not in hospital for prolonged periods of time. This is perhaps reflective of today's society where individuals are perceived as wary of socialising with strangers and therefore making acquaintances is often problematic (DeCew 1997; Cohen 2001; Cooper 2003). However, one mother who was admitted for a longer stay shared her positive experience:

'I had three people sharing my room and one of them read a book on adapting to your baby after giving birth and I couldn't relate to her experience at all. And then the two other women who were in there were going through all the difficulties of adapting to a new baby and in a way that helped me to go through it with them. They became friends in hospital and I still have contact with them.'

(FG5)

This mother described how a sense of camaraderie with other mothers created a common bond between them and where this appeared to be absent, such as when mothers remained in hospital for short periods of time, then intolerance developed because of the lack of commonality. Mothers within the study wanted privacy from interactions, by being able to withdraw from social contact and initiate interactions when, and if they desired:

'R1 It's about having my own space, so when I want it, it is my personal space.

R2 I don't think it's about being on my own all the time or just if you want to, you have the right.'

(FG1)

The concept of negotiating personal space also occurred outside of hospital environments as one mother explained:

'My brother actually didn't like watching me breastfeeding the children so if I was there and I was feeding the baby then I go somewhere else to do it. If I am away at somewhere like my in laws they have a room upstairs with an armchair in it. I started off going up there in the beginning because I felt more uncomfortable feeding around his family and his father or when his friends would come around. So I started off disappearing upstairs because it was less distracting for the baby anyway.'

(FG 6)

In this situation positive withdrawal empowered the mother to feed her baby without fear of being observed. Withdrawal, solitude and isolation in relation to privacy have been portrayed in the literature as associated with control individuals have over their situation, moving between periods of withdrawal and interaction with others (Proshansky *et al.* 1970; Steiner 1970; Inness 1992; Boling 1996). Within this study the need for withdrawal emerges as linked to mothers' need for personal space, that is, time to be alone or to be with close family or friends, particularly as control over personal space enables individuals to facilitate their unique behaviour patterns (Woogara 2004; Rossler 2005) defined by mothers as *'doing what they want'*. This involved feeling relaxed and comfortable in their surroundings, being able to read if they wished, listen to music, or lay or sleep on their beds during the day without fear of being interrupted, watched or listened to.

Within wards not only was withdrawal difficult to achieve because of a lack of personal space but mothers had to contend with other people within the wards. They described how, during visiting, there were rapid increases in the number of people within the environment, which impacted on their ability to gain privacy. This was particularly problematic within wards:

'I remember being really tired after two nights of not having any sleep and just going to sleep and then visiting time came and all these people came piling in and I thought oh no! I was just about on the verge of sleep.'

(FG5)

'Afterwards your baby just drops off or your baby starts to cry when visitors come and wake your baby up. All that can work towards an unsettled baby I'm sure. Why have that agro?'

(Jessica Interview 1)

The number of visitors on wards was often described by mothers in focus groups as excessive and as compounded by heightened noise levels and inappropriate actions of both visitors and their children, which breached both personal space and what will be discussed later, auditory privacy. They described limited policing of visitor numbers in wards by staff, suggesting that by actively

restricting visiting to shorter periods of time, staff had in effect, prompted larger numbers of visitors to arrive simultaneously. This was witnessed during observations when it became impossible at times to observe interactions of participants, because of the sheer volume of visitors within the room. While mothers in the study complained about visitors within the focus groups, none complained about their own visitors in the context of the ward; it was always someone else's visitors that were problematic. One mother described her feelings at the end of visiting:

'Because there are just so many people (during visiting). At bedtime we were all shut away with our babies and it was wonderful to have this enforced because the families are all so big and all the family is taking an interest in the baby and they know what the boundaries are and it is official and nobody could move them.'

(FG5)

Mothers within the study recognised the need to restrict visiting late in the evening because of their need to gain periods of relative privacy away from visitors. Mothers described relief when visiting time finished and they were able to secure their space, considering the strict visiting rules as there for their protection when they felt vulnerable and emotional.

There were other mothers within the study whose experience with privacy differed during childbirth and the early postnatal period, namely those mothers with babies in Special Care Baby Units (SCBU), and those who delivered their babies at home. Mothers within focus groups who had babies in SCBUs invariably found themselves either seeking contact with other mothers, or needing to withdraw to avoid contact, whereas mothers having a homebirth described their reasons for doing so as needing to be isolated from others. The following mothers explained:

'She (the baby) was in SCBU for quite a long time and they did give me a side room I wasn't put on the maternity ward with all the other mothers, so in that respect it was very good. I wouldn't have been able to cope without that. I was a bit depressed anyway because I didn't have my baby with mePeople in the ward thought that something awful had happened because you obviously haven't got your baby with you.'

(FG3)

'I didn't think it was so private because my baby went into special care baby unit and I could hear other people's babies in the night. I was able to chat with them about what they were doing with their baby because I didn't have a baby with me. So in some respect the lack of privacy actually helped me.'

(FG5)

The privacy needs of these two mothers differed, emphasising the uniqueness of privacy to the individual. By making a choice as to whether they should be accommodated in a single room or in

an open ward, mothers were able to take control of their privacy and use contact or lack of contact with others to their advantage.

Two mothers in the study experienced a homebirth and this offered an alternate insight into why mothers decided to remain at home. While most mothers have their babies in hospital a small minority (2%) choose to have their babies at home (ONS 2006). The reasons given by these two mothers included a dislike of hospitals, not wanting to be around others, wanting to be at home in their own environment, wearing their own clothes and being able to choose their visitors:

'I don't like going to hospital for anything. I tend to start shaking and feeling unwell..... just being in my own clothes at home was lovely. Because you are at home you can do what you like and you can be calm and relaxed. A friend of mine came to help. She helped me at home and stopped too many people visiting because they would just turn up and she was able to answer the door and tell them to come back later.'

(FG 4 - Louise)

Both mothers who selected a homebirth described feeling relaxed and rested following birth, portraying their births, as one mother put it, as very *'private and tranquil'*. One mother described how she had switched on her answer-phone during the postnatal period to stop verbal intrusions, while the other used a friend to act as *'visitor monitor'* to police access to her home without causing offence to callers. These circumstances enabled mothers to feel in control of their environment securing their privacy as, and when, it was required.

Mothers in early or passive labour were generally admitted to antenatal wards or transitional wards on a delivery suite. In retrospect mothers felt they should be allocated a single room at the commencement of labour, perceiving the lack of this appropriate accommodation to result in a sense of compromise at a time when they considered isolation and security ready for the birth as a necessity. As soon as labour commenced mothers within the study described how they wanted single rooms in which to create their own space. However, because of the uncertainty of labour mothers wanted this accommodation as soon as *they* perceived themselves to be in labour and not when diagnosed by midwives. One mother described her experience on admission:

'I went in and they sent me home and said if you really want to come back in you can come back in, so I went back in, but I was shoved in a waiting room. You are trapped in the waiting room with people walking about. They didn't want to put me in the delivery suite because they didn't think I was far enough advanced.'

(FG1)

Having their own room on delivery suite was perceived by mothers in the study as a *'luxury'* and something to which *'everyone has a right'*. When this was denied it resulted in a feeling of being trapped and ignored:

'No, not at all (asked if she felt relaxed in this ward). I hated it. Every second of it. I felt very tearful and very upset just because it wasn't how I wanted it to be.

(Interview 1 – Jessica)

In the postnatal period mothers in the study also wanted single rooms in which to rest and recuperate, rather than overcrowded ward environments. Overcrowding has been shown to influence competence and task completion (Desor 1972; Rustemli 1992; Nijman and Rector 1999) and when applied to ward environments also reduced mothers' ability to rest. One mother gave her view:

'What really got me afterwards was that they put me in a room on my own which was great and you felt so tired. Then they wanted me out of that ward that night and on to the ward I was still really, really tired and I was really looking forward to a good nights sleep even if it was only for one night in my own room, but I had to move out because another mother wanted it. ...Whatever sort of labour you had you have the right to have a good night's sleep after it and you don't get it, any kind of privacy, on the ward.'

(FG 5)

Overwhelming tiredness was a common condition described by mothers within the study following birth and it was perceived that having access to their own room would have facilitated rest without constant interruptions. Where mothers particularly wanted their own room and had the means to pay, amenity rooms were available. One mother paid for such a room to gain privacy, asked what the important factor about having this room was, she replied:

Jessica: The privacy. The privacy factor.

Facilitator: And what was that?

Jessica: Just the fact that it would be mine, without everybody else overhearing, everyone seeing the grimace on your face if you are in pain. Obviously there is a point where you don't put up with them (others)..... The privacy factor was very important especially afterwards..... it gave us time to bond as a family.'

(Interview 1- Jessica)

Having a single room in which to be alone with their new baby was often singled out as a priority for mothers within the study. Mothers described how the immediate postnatal period was a very private time for them and their close family and friends, and in retrospect one in which privacy gained from single room provision was a necessity, not an option.

As single rooms were generally not available to mothers within the study due to lack of current provision, they described trying to gain space by pulling curtains around their beds. However, in reality the use of curtains did little to afford them any privacy, as one mother explained:

'... people kept coming in and out of the curtains and they don't always put the curtains back when they are coming in to do different things and I found that there wasn't much privacy there. But once you got to the actual delivery they seemed to be much more astute to it, which was quite off really you would have thought that it would have been the other way round. But as you say by the time you get to the delivery room you are not aware and I couldn't have cared a less what was going on.'

(FG 1)

This mother suggested that obtaining a single room in a delivery suite was actually too late as she actually needed this type of accommodation in which to labour, rather than the open environment of the ward. While having personal accommodation was perceived as the ideal by mothers in focus groups, in retrospect problems with securing privacy within ward environments were compounded by the attitudes of staff.

While mothers considered ward environments problematic for the procurement of privacy, they also described how staff often added to the problem with attitudes that they found patronising and demeaning. One mother explained:

'As a patient who popped into the unit I was completely taken apart in the environment that they make you stay in. I was not there because I wanted to be. I was there because I was 16 days over, there were no more options for me, it wasn't like I was there because I had weeks (until end of pregnancy) I was there because I had to be in there.'

(Interview 1- Jessica)

Other mothers within the focus groups added:

'I found that afterwards they were terribly patronising in the ward. It was like some terribly strict girls school.'

(FG5)

'I was bleeding all the way. Then some midwife comes up and says 'who's been bleeding down my corridor' you know, shouting it out and I couldn't help it.'

(FG3)

Mothers within the study felt reprimanded for bodily functions out of their control and having this emphasised in a public forum enhanced their sense of embarrassment and incompetence. This sense of embarrassment coupled with a sense of helplessness and loss of face resulted in them feeling humiliated, degraded and vulnerable in an environment of chastisement where they became

incapable of supporting their own privacy needs (Goffman 1961; Kelvin 1973). Mothers also described being in a mothering role while being treated like children by staff:

'I felt that we (her and her partner) were a bit bullied at first and then when we started to say 'well we don't want to' then I think they took things a bit more in respect.... I could imagine if you weren't assertive and fairly laid back that you would just get rolled over.'

(FG 1)

When mothers felt bullied and intimidated by staff, it was often left to partners to act as advocate on their behalf. The partner of the mother in the extract continued to question on his wife's behalf and her perception was that he appeared happy to adopt this protective role; however, the outcome of the encounter was that they perceived themselves to be viewed as 'stropky' and a nuisance, by staff.

In contrast, one of ways in which mothers within the study perceived staff as promoting their privacy was through maintaining 'good manners' or social etiquette such as knocking on doors and asking permission to enter. The following mothers gave their opinions:

'Often wherever you are then people can invade your space they (should) basically say 'is it alright if I come in or if I talk to you about this, so it's really being asked.'

(FG 1)

'They knocked on the door, there was a curtain around the door and they did explain what they were doing. That was quite good...'

(FG1)

During observations, however, there was little evidence of staff knocking on doors or asking consent for admission. On reviewing my own actions on a visit to the fetal medicine unit, I reflected upon how I knocked on a door and entered the room before the person inside acknowledged entry, and found the mother having an invasive procedure. The result was embarrassment for me and I feel sure, embarrassment for her. Where staff knocked at doors and requested to enter, mothers within the study considered their privacy within their control, projecting a sense of ownership. Mothers' perceptions were that staff had professional right of access to their rooms without consent or knocking because of their need to monitor them, particularly in emergency situations. The impression of mothers within the study was that staff had forgotten basic etiquette or good manners and this reduced the feeling of respect between them and midwives.

In summary, mothers within the study often entered the maternity services with an idealised perception of what would happen to them once within the hospital environment. Once admitted to wards in particular, they found cramped wards, overcrowded with people who often did not show respect for the privacy needs of others, and staff who were sometimes patronising. It is within this environment that mothers attempted to secure personal space. The need for withdrawal or solitude, through which to achieve personal privacy is associated with freedom of self definition (Fried 1970; Rossler 2005), required to *'break from role-playing and the opportunity for 'making fools of ourselves'* (Rossler 2005:149) and needed for *'desocialisation'* from others (Halmos 1953). Withdrawal can be identified within this research as the need for mothers to be able to withdraw from social interaction with other mothers and visitors in an attempt to escape from overcrowded rooms, being viewed while breastfeeding or from interactions with strangers. In this instance mothers in focus groups described having little control over their privacy maintenance and felt open to further breaches in privacy through disclosure of personal information.

Eavesdropping and Disclosure Privacy

One of the greatest problems with open ward environments was the fact that mothers and visitors eavesdropped on the conversations and actions of residents. The structure of hospital wards is such that residents found themselves in close proximity to peers where it was easy to overhear their actions and conversations, whether intentional or not. The term eavesdropping has become synonymous with covert or sinister activity, used to elicit private information about an individual (Young 1978; Rossler 2005). Once information is gained this is usually used to the detriment of the person. However, eavesdropping, or choosing to listen in to another person's conversation within this research also concerned mothers listening to conversations or noises of others, usually to glean information about treatments or the progress of pregnancy, or to uncover an interesting story about another resident, or just being in a position where you have no choice but to overhear.

Eavesdropping works both ways as participants became either eavesdroppers or the victims of eavesdropping. It is important to state early on that eavesdropping in the context of this research is not generally perceived as malicious but more a matter of gathering clues when in an uncertain situation. Where mothers within the study eavesdropped into conversations regarding examinations, they related this information to their own situation to anticipate their own next course of treatment. The different types of eavesdropping discussed within this section include:

overhearing others in pain or during examinations, hearing the personal details of another person in close proximity, or having your own information disclosed by another. Being overheard when compromised, no matter what the circumstances, reduces a person's integrity and increases their sense of vulnerability. Mothers within the study have a picture of themselves which they want to project to others, based around portraying an image of being 'good mothers'. When their personal information was exposed they felt this image was compromised,, resulting in them feeling incompetent or losing face. This posed the question what role does eavesdropping or overhearing play in relation to questions of privacy for mothers?

One of the founding principles of privacy is the desire to be free from intrusion or public attention (Prosser 1960). This section presents data to show how mothers in the study felt they became the centre of public attention, when in early labour in ward environments. Firstly, they described how they viewed each other because they had no other form of entertainment and secondly, to determine impending events. The process of being in labour was new for most mothers within the study and they recalled how they were unsure of how to act. What mothers did not want was to appear incompetent during the process of giving birth or developing their mothering skills. Their greatest fears were associated with events which they felt were outside of their control such as, spontaneous rupture of membranes and the fear of delivering their baby in public. These are ideas portrayed in popular media press where pregnant women are shown as delivering their babies quickly following commencement of labour or rupture of membranes. Birth in itself is a unique experience made more intriguing for mothers in this instance by the fact that they would soon be going through the event.

Overhearing and Being Overheard

Mothers in the study described how being in early labour or being induced resulted in them being placed in wards with non-labouring mothers, or new mothers and their babies. In this environment they felt watched or listened to and unable to remain private at this personal time. They wanted to perform in labour how they wished, in an environment where they were safe from intrusion. Instead mothers found themselves having intimate examinations behind curtains during visiting, labouring around other mothers and overhearing others' personal details during ward rounds and mother/practitioner interactions. During admission mothers were cared for within 4 – 6 bed rooms, having all of their treatments and examinations undertaken within this public environment.

Treatments and examinations undertaken included insertion of vaginal pessaries, vaginal examinations and daily examinations of abdomen and vaginal loss. While these treatments were not usually problematic if undertaken in a more private environment, they became problematic when completed in the public environment of the ward.

Once bed curtains were pulled, the power of the imagination was such that mothers envisaged eavesdroppers visualising invasive procedures using the explanations and graphic descriptions of events given by midwives to mothers during the procedure. The following mothers explained their experiences:

'I think it depends where you are because I was in the ward with 6 other women that was fine when they were coming round giving you treatments, but they were quite painful and some of them were due in visiting times when men were there and all you have got is a very thin curtain and some treatments that are quite intimate. You know, they are being described to you exactly what is going to happen and what you are going to feel and then they are pushing and shoving and what have you, and you are reacting to this, or are going to and on the other side of the very thin curtain you know, is a lady with her family and her husband and what have you. I found that most embarrassing.'

(FG3)

'I never, ever, ever, had an internal of any kind and all of a sudden it is done with a curtain around you with 6 other people. As discreet as they try and keep it, it is not particularly nice.'

(Interview 1- Jessica)

'I was more tense because there were people knowing what was going on.'

(FG3)

'This person just arrived and said 'right I am going to put this pessary in' and nobody told you how awful this was going to be, on the ward there was just like a thin curtain around you and like other women on the ward as well and it was horrible. I really felt like screaming out, 'ouch, ouch' they are hurting me'.

(FG4)

'Being in labour is a bit like doing your cycling proficiency badge, you don't want people to see you in pain or falling off your bike as you feel such a prat. You just want them to see you at the end when everything is ok.'

(FG 2)

Induction of labour and insertion of vaginal pessaries caused mothers in the study most concern. Focus group members were concerned that they would scream and embarrass themselves and others and had the perception that staff thought curtains provided enough privacy in this situation,

and although this maybe the case with protection from visual observation, this was counterproductive when midwives described in detail, the process of examinations. One mother stated:

'That's it, you are private but you are not, you can hear everything'.

(FG2)

Mothers expressed within their focus groups a sense of loss of control over personal details and intimate aspects of care. The perceived loss of face and subsequent embarrassment caused to mothers was enhanced by what they saw as silent acknowledgement of their experience by other people present in the room. As curtains were drawn back, mothers in the study had the perception that each person in the room had envisage what had occurred, and so they were embarrassed. One mother when discussing the implications of her care in the ward said *'I hate to think about it'* while another mother suggested the use of a *'treatment room'* where they could go for treatment, *'just you and the midwife'*, without the fear of being overlooked or overheard by others.

Being overheard influenced mothers' ability to be themselves and act as they wanted, by *'screaming out'* or *'moaning'* during labour. Mothers in the study felt inhibited in the presence of others, with mother concluding:

'I hated it. I was in agony, in absolute agony, trying to keep the noise down because I was conscious of other women.'

(FG3)

'I didn't want them to think that I couldn't cope, that I didn't know what I was doing, but we were all in the same boat and looking back none of us had any idea, it was a new experience for us all, but at the time you feel frightened and useless.'

(FG 5)

Emotions ended up being suppressed because mothers did not want to be overheard by others. They described being acutely aware of the impact their actions had on other room occupants and described not wanting a *'loss of face'* in front of others, revealed as not being able to cope with pain or of making a fool of themselves, which was in turn perceived by them to reflect incompetence and their failure as a mother.

'I had no idea what to expect (in labour) and felt stupid and useless. No-one else should see you like that I didn't want anyone else to see me like that.'

(FG 6)

'You don't know how you are going to behave in labour and you don't want people hearing you or seeing you, because you are worried that you are not doing it right, not doing it properly.'

(FG 3)

Where mothers described being unable to cope with examinations or pain and being overheard by others, this resulted in a sense of shame and loss of face (Goffman 1959; Goffman 1963; Rykwert 2001). This was compounded by the perception that midwives *'aren't bothered'* about their privacy, in relation to their pain or discomfort. One focus group member stated:

'It is of absolutely no importance (privacy) to the staff there at all. Because you are on the production line, in fairness to them, they are racing around like people possessed there is hardly any staff and there are far too many people and they have to try and get on with the job in hand and unfortunately as quickly as possible.'

(FG 3)

Mothers' perceptions within the study of being on a *'production line'* did nothing to enhance self worth or empowerment, resulting in feelings of stupidity, uselessness, vulnerability and disempowerment. As staff were perceived as too busy, it was seen as inevitable that privacy became compromised and care became something which was *'done to you'* without regard to your privacy needs, while completed in a busy and overcrowded environment. One mother described her feelings on admission:

'I felt very much like perhaps like a labouring cow that was left in there, in her corner shed and left to get on with it.'

(Interview 1 – Jessica)

Mothers associated the onset of labour with onset of pain, however minor. Often, as was seen during participant observation, they laboured in wards behind closed curtains, resulting in other mothers overhearing them during labour, without witnessing the event. This can perhaps be linked to the experience of visiting the dentist, where the dental drill is heard and the level of perceived pain enhanced, even before the surgery is entered. Overhearing another mother's pain was deemed by mothers in focus groups as an extensive privacy breach, at what they perceived to be a private time:

'There were people in the early stages of labour in beds around this ward with only a curtain around them, who were clearly in pain, there were people moaning and so on and I thought I can't face this..... I thought that there was no privacy for me.'

(FG1)

'She (another mother) was in a lot of pain on the ward and it frightened me so much and I couldn't help her.... I felt really sorry for her and I could hear her breathing and shouting out. I think it is the real fear of the unknown. It is just awful.'

(FG5)

'There were all these women, I think it was busy downstairs (on the delivery suite) and they would be walking up and down, moaning in pain and waiting to go down and we would have paid the midwives not to hear that.'

(FG5)

Overhearing someone in pain creates a terrifying picture of events in the mind of mothers, heightening their anticipation of pain and increasing their fear and sense of helplessness. Although mothers in labour generally described being in wards with other mothers, they tended to conceal themselves behind closed curtains. This resulted in other mothers hearing their responses to pain, rather than witnessing its management. The following mother explains:

'I was in the antenatal ward beforehand for the night and there's not much privacy there because you have only got a curtain and there were people going into labour even in the ward next to me that you could hear through the walls. You do start to conjure up all sorts of thoughts...'

(FG 1)

The fear and anticipation of pain was so great in one mother within a focus group that it resulted in her requesting pain relief prior to its need:

'I was terrified of the pain, so I think retrospectively, I probably had the epidural far too soon, which was why the labour didn't progress.'

(FG5)

Early administration of an epidural is known to increase obstetric intervention and operative delivery (Beilin *et al.* 1999; Zhang *et al.* 1999) and in this case may have increased the risk of an instrumental delivery.

Once pain commenced, mothers within the study argued that they should have been transferred to a single room on the delivery suite. In retrospect, they felt they were kept on wards far too long and in so doing were deprived of the privacy of a single room. They determined that if labour progressed to the point where they were in pain, then they should be *'allowed to go on to the delivery suite'* and that decision should be theirs and not the practitioners, the rationale being:

'When your labour does start, you need to be taken somewhere even if it is not delivery suite because they can't take you (on delivery suite), but a side room, where you are not worried about screaming in front of a lot of people.'

(FG3)

Overhearing or being overheard in pain was not the only perceived breach of privacy in this respect. As the ward environments were spatially cramped, mothers were acutely aware that other mothers would overhear conversations involving personal aspects of their life, or pregnancy, accepting this as routine during admission to hospital.

Overhearing Personal Information

Unintentional overhearing or eavesdropping was perceived as common by mothers in focus groups, and occurred on admission to hospital, irrespective of the area of admission. Because of the confined and crowded nature of wards, mothers described how it was often difficult not to inadvertently overhear conversations taking place, even if they tried not to. One mother in the study gave her view:

'You can hear everything that is going on in the other bays for want of a better word. You don't have any privacy at all. You can hear everything, especially on the antenatal side of things. On the postnatal side probably it's not as important because you have had the baby and they are lovely and they are all right. If you or they are not all right they wouldn't put you in a communal ward. But on the antenatal side you are all a bit worried that something might be going wrong because you are not in the antenatal area as routine, so there is some problem and you have no privacy there at all.'

(FGF 4)

'It's not just maternity, is it? It is every hospital ward, you know, if you have major heart surgery everybody is going to hear. It is the way the hospitals are built actually.'

(FG 5)

'They can hear everything about you, (that) you have high blood pressure or you're bleeding, it makes you feel like it's your fault, like your body isn't working properly and I felt that I was useless and couldn't do it (pregnancy) properly.'

(FG5 5)

The impressions given by mothers during focus groups were that layout and overcrowding of wards were not conducive to privacy and no matter where in hospital you were admitted the resulting experience was similar. Mothers in the study described overhearing as problematic in wards and more so in the antenatal than the postnatal period. In the antenatal period mothers listened to conversations to compare the health of their baby to other peoples' circumstances, and to determine what could happen to them in the near future. Unfortunately the result was often that they speculated what was going to happen to them and their baby, based on other mothers' conditions, which bore little resemblance to their own.

Even where bed curtains were used in an attempt at privacy, overhearing still occurred. Mothers in the study perceived staff to be unconcerned that others could overhear conversations from behind curtains and were considered by mothers, not to acknowledge this as problematic. These two mothers discussed the issue:

'R1 You can hear everything that is being said. Absolutely everything there is no privacy at all.'

'R2 They do think that's it (pulling curtains around gives privacy), you are private but you are not, you can hear everything.'

(FG4)

Once admitted to a ward there were relatively few distractions for mothers within the study, other than listening to surrounding discussions, whether consciously or subconsciously. As the baby's health was paramount to prospective mothers they listened to conversations in an attempt to discern the possible course of action for their own pregnancy. In one observation episode I spoke to mothers in a 6 bed ward to ascertain information on a mother who was behind bed curtains for most of the day. Two mothers gave me a detailed history of the mother's condition and her state of health. There was no regard to confidentiality and they appeared to enjoy telling me about the horrors this mother had endured. It was surprising to me to hear the level of knowledge they had about this mother as they talked through the woman's pregnancy and social life. This information had been gathered by eavesdropping on conversations between the mother and her carers.

Although client discussions had the potential for disclosure of personal information it was often general discussions by healthcare professionals in public areas that revealed information about individuals and thus breached their privacy. Mothers in the study described disclosures occurring in the antenatal period via third party discussions, shouting down corridors, overhearing others conversations and discussions at nurses' stations. Conversations also occurred during the postnatal period but via different conduits, such as telephones or ward rounds.

Conversations with practitioners were commonly held in the ward environment, either at the end of the bed or behind drawn curtains. Often these conversations were clearly audible to other room occupants:

'That was the one thing that she did (the consultant on reviewing the mother's records), to beat up the Australian doctor who wasn't in the room at the time, she left

the room and shouted down the corridor at him about everything to do with my X Ray and my details. That was a bit awful.'

(FG 2)

In this instance the mother appeared totally unable to intervene in events with the outcome being an increased sense of inadequacy and failure and disclosure of her physical inadequacies to the rest of the visitors in the room. There are clear guidelines available to practitioners on their role in maintaining confidentiality of clients published as a Code of Practice for practitioners (DH 2003). Disclosure of information has the potential to reduce the trust between mother and midwife, in turn reducing perceived respect (Curtin 1986; Rylance 1999) and has been shown to impact on psychological wellbeing during hospitalisation (Barron 1990).

Staff were not alone in being responsible for disclosure of personal information, as mothers in focus groups told how they made telephone calls to friends or relatives following the birth of their child and how this inevitably included a detailed discussion of their labour and birth. Mothers described how they needed to discuss events with their own mothers and close friends to reassure them they were okay and to tell them about their new baby. The idea of others having access to this information was seen negatively by these mothers and they did not particularly want other mothers or visitors to share their birthing information. In one incident a mother described how she was present in the ward when a young mother was admitted following an undiagnosed pregnancy. The woman was offered a trolley phone and proceeded to have a discussion with her mother within hearing distance of five other mothers in the ward:

'There was a woman directly diagonal opposite from me who had come in and she was going to be a nurse and didn't know that she was pregnant, had gone to casualty thinking she had appendicitis and basically everybody including the four of us in that room knew precisely what was going on, even when the social worker came to see her to see whether she wanted to keep the baby, or she didn't, because she was a student nurse, everybody heard the whole saga of it and she couldn't get out of bed for a time, so they had to bring in a telephone while she tried to ring her mother, I mean two of the women in there were actually quite nasty about it and laughing that she didn't know that she was pregnant, I made friends with her but if it had been me I certainly wouldn't have wanted that lot of my business broadcast around the whole area.

(FG4)

While this may be an extreme incident, telephone conversations to family and friends were commonplace. Another mother described her experience:

'It reminds me of making my phone calls, like when you get taken to the postnatal ward and you make your phone calls to your family and they all want to know the details and you are broadcasting it and I had quite a difficult birth and I wanted to tell my mum everything that had happened and have a good cry about it, but I couldn't because there were all these people listening and everyone's husbands were there going (puts hand to ear).'

(FG1)

The picture of visitors listening into conversations of mothers was perceived by them as eavesdropping, whether it occurred or not. Mothers were sure that it happened because they themselves could overhear the conversations of others and therefore were aware that it could be reciprocated. While overhearing on wards was perceived as problematic, mothers within the study also described overhearing practitioners during an emergency.

Overhearing Practitioners during an Emergency

Mothers in the study who experienced an obstetric emergency described how their senses were heightened when they realised they would be having an operative delivery, with the result that they became acutely aware of surrounding events and listened for possible complications and news of their baby. The following mother explained her experience when she overheard doctors discussing a problem during the birth:

'I don't know if it was privacy or just that they were discussing you and not involving you. I could hear what was going on, on the other side of the screen and you know you begin to panic. Two of the surgeons were saying things to each other, like 'do you know why that happened, that happened because you did' and I couldn't hear the rest of it and I thought goodness gracious what have they done? It turned out that in fact they thought they had snipped my bladder ... That was a thing where either I should have been told or they should have made sure that I wasn't hearing any of it.'

(FG 2)

Overhearing under such circumstances understandably increased mothers' anxiety and resulted in a sense of fear and panic. During operative procedures mothers were not in a position to question or interject into conversations and having little or no medical knowledge were unable to question what was happening. In these circumstances mothers behaved as '*conscious, unconscious patients*' that is, their body responded as if unconscious and was treated that way by practitioners, whereas their mind stayed alert and conscious and processing information, increasing their overall awareness of events. As overhearing conversations during caesarean sections can be distressing for mothers, some even took steps to prevent its occurrence should operative delivery be necessary, as the following mother described:

'Because we actually had more time to prepare we actually put in the birth plan that we didn't really want a running commentary of what they were doing because I would be like that, I would be wondering and if I couldn't hear it properly I'd panic and worry so they actually didn't discuss anything that they were doing.'

(FG2)

The outcome was that commentary did not take place and the mother retained her sense of being in control and empowered within the setting. While overhearing resulted in disclosure of information mothers were aware of other conduits that enhanced this process, such as through hospital records.

Disclosure of Personal Information In Records

Although disclosure of information predominantly occurred by overhearing and eavesdropping, mothers within the study were also aware that it occurred through maintaining and recording information within records, which were then subsequently reviewed by a third party. All mothers are issued with a set of midwifery/obstetric records at the midwives booking visit, which they then carry with them. Mothers within focus groups discussed their views on policing access to them:

'R I showed mine to my mum just because she asked to see it. There was nothing new in there.'

R No-one asked to see my notes and I don't know if I would have let them or not.

R Obviously you give them to the doctors, midwives and all the rest of them, but friends and family I don't know. But they (the midwife) were very sensitive about it, and I had a couple of pregnancies before and they asked me if I wanted them to go in the notes, just in case somebody were able to trace your records, it was quite nice for them to actually ask.'

(FG4)

Controlling access to personal information during the antenatal period prior to admission was not challenging for mothers in the study, as they carried their notes around with them. It was more common within the study for mothers not to share their records with others; however, access was not always initiated by the mother. In one focus group where partners were present, one father stated he had read his partners records without consent (although the mother did not appear perturbed by this). The perceptions of mothers in the study were that records belonged to midwives and they were just *'allowed to carry them'* until the birth. Because they did not own the records mothers portrayed the reading of them as a covert or illicit activity, completed after the midwife's visit. Only one mother in the study expressed concern over carrying her records:

'I say though the negative of having your own notes is the worry about loosing them, because I am terrible at loosing things and pregnancy doesn't help. I did lose one set of notes once and that was the only time my blood pressure was high.'

(FG4)

As mothers carried their records with them at all times, the risk of loss was perceived as being minimal and generally not a cause for concern.

On Bodily Exposure: Privacy and Loss of Inhibition

The previous section outlined the impact of eavesdropping on the enhancement of privacy. This section describes how mothers in the study perceived their privacy status to be influenced by bodily exposure and loss of inhibition, and how midwives and doctors treated them as objects. Mothers' perceived privacy was not an issue for midwives, as their aim was completion of tasks to ensure the safety and wellbeing of mothers and babies. The questions posed for this section are; Do mothers' notions of privacy change to accommodate the situations in which they find themselves and what aspects do they acquiesce or resist? How do mothers feel about bodily exposure during pregnancy and childbirth and what impact does this have on their privacy? How does the standard and type of care offered by practitioners influence mothers' perceptions of privacy? Do mothers lose their inhibitions and ownership of their bodies because of over exposure to physical examinations and constant viewing by others? What strategies do mothers employ to manage exposure of their body and to ensure the safety of their baby? What emerges is that mothers intentionally handover salient aspects of their privacy to midwives while managing their pain, temporarily disowning privacy management during birth and that this process is facilitated by communication, explanations, trust and a humanitarian approach to care.

In some cases mothers within the study described adopting the role of inanimate object in order not to influence the work of doctors and midwives when the safety of their baby was perceived to be compromised. Adopting this role was sensed as positive by mothers as a short-term requirement necessary to achieve their primary goal of a healthy baby and safe return home. Alternatively, mothers perceived practitioners to ignore them during interactions resulting in objectification of their body. In order to decrease a mothers' sense of objectification they suggested that practitioners needed to actively involve them in decision-making processes, develop with them a sense of trust, and enhance their feelings of control over events and their pregnancy, all within a caring, friendly environment of care.

Loss of Inhibition and Objectification of the Body

The repetitive nature of antenatal physical examinations mothers within the study associated as responsible for their loss of privacy inhibitions. An inhibition is a form of defence mechanism or barrier put in place for protection from actions or embarrassment, or a restraint on behavioural instincts, which in relation to this study, were linked to mothers' lack of control over who had access to their body. The outcome of inhibition loss was a decrease in embarrassment and shame during examinations, with an eventual transfer of privacy management and control of their body to the midwife. Objectification of the body is a term associated with client/practitioner relationships where the practitioner objectifies the patient's body in effect disassociating themselves from the invasive treatment or care to which the body is subjected, thereby reducing the need to communicate with the person or acknowledge their presence. Goffman (1961:298) described this process as 'non-person treatment',

'whereby the patient is greeted with what passes as civility, and said farewell to in the same fashion, everything in between going on as if the patient weren't there as a social person at all, but only as a possession someone has left behind.'

While objectification of the body is not a term explicitly used by mothers, their accounts can be related to its concepts; what mothers in the study described as losing their inhibitions or being ignored by staff during interactions. One mother explained:

'R I seemed to lose my inhibitions a bit.

Facilitator: What after you had the baby?

R No, before I think I got so used to being prodded, you just get used to it as a way, it is one of those things that you have to accept when you have your checks on a regular basis. You just have to get used to it.'

(FG3)

The process of being prodded resulted in a perception of care as something which was '*done to you*' rather than mutual activity between parties. The process of being '*prodded*' and examined during pregnancy intensified as pregnancy progressed with mothers in the study describing first how they became accustomed to abdominal examinations and then to more physical and invasive procedures as pregnancy progressed. Participant observations in practice also showed how mothers would often require minimal prompting to expose their bodies for examinations, often exposing them before being prompted by the midwife. Once desensitised to examinations, mothers considered them routine, legitimising exposure as necessary to ensure the health and wellbeing of their baby. The repetitive nature of examinations meant mothers relinquished control of access to their bodies during such procedures, as they became familiar with the process, accepting this

monitoring procedure as key to their pregnancy, stating that it *'no longer bothered me'* or that they *'didn't care'*.

The eventual outcome of inhibition loss mothers presented as *'your body is not your own anymore'* (FG4) with access to the body relinquished and autonomy compromised. Having a sense of control over personal circumstances and interactions is central to maintaining a sense of ownership over the body (McHale and Gallagher 2003) and necessary for privacy maintenance. Where ownership of their body was within their personal control, mothers described being able to manage and deal with repetitive examinations and bodily exposure. Alternatively, where inhibitions were decreased the sense of embarrassment and shame experienced declined and ownership transferred to the midwife. Mothers then perceived midwives felt able to legitimately perform tasks on their bodies without explanations:

'I don't think that it is explained enough what they are doing and why they are doing it and why it is necessary. It was just a case of right here we go, and you just lay back without any sense of explanation really.'

(FG 1)

Lack of explanations prior to what were considered routine procedures, mothers explained, resulted in depersonalisation, a decline in interactions with professionals and a reduction in the need to show them respect. The process of informed consent is explicit within healthcare professional guidance, which clearly states the need for explanations prior to all procedures (Berg *et al.* 2001; Aveyard 2002; RCN 2005) but mothers felt this did not occur and therefore they were not treated as equals or with respect by staff. Where no explanations were given mothers felt midwives breached privacy through a lack of respect.

Embarrassment was a common outcome described by mothers following an instrumental delivery, linked to feeling exposed and vulnerable following the use of stirrups during delivery, particularly where mothers felt unacknowledged by staff during the process. The following mother described her experience:

'... when they were stitching me up they had put stirrups on the bed but they couldn't get the stirrups to work properly so they were joking between themselves and trying to do this, while I was lying there thinking 'oh my god, I don't believe this'.'

(FG 2)

The lack of involvement during this type of experience heightened mothers' feelings of embarrassment and shame at being handled in this manner. By not acknowledging the mother as a person, staff created a perception in mothers that they were actively ignoring them, dehumanising the role they played in the event. This associated with a lack of personal acknowledgement of their involvement in the situation gave mothers a sense of disbelief in what was happening to them.

Good social skills, what could be construed as good manners, such as, acknowledging the presence of the mother, personal introductions, or asking permission, mothers in focus groups tended to dismiss as legitimately absent during emergency situations, because of the urgency of the delivery, using this to reason away imperfections in practitioners' approach. Lack of informed choice was nowhere more evident than during emergency situations; mothers in the study described how as the situation quickly changed, with a subsequent increase in staff, reduction in social niceties or anomy, such as introductions or informative communication. Social norms associated with privacy were put into abeyance by mothers because of their perception that staff needed to assess the wellbeing of their baby:

'Some of the time they don't even ask you do they? Like this manipulation, moving him, his spine was on my right and they wanted it on the left and she just shoved her hand inside and off you go..'

(FG 3)

"I just think maybe because it was quite kind of quick at the end with forceps, they said we need to whip it out, you need the forceps and because it was quite urgent to get her out that quickly that maybe there wasn't sort of time for the 'hello I'm' the niceties..... You know they just came in and they just did it.'

(FG4)

In an emergency situation, such as forceps or operative deliveries, the priorities for staff were considered by mothers to change, with the need to enhance safe delivery of the baby becoming paramount. They described how invasive procedures were performed more frequently by staff when emergencies occurred, with examinations performed by doctors described as uncomfortable and painful, involving '*pushing*' and '*shoving*', and performed to their body and not physically to them. It was emergency forceps deliveries which facilitated objectification and dehumanisation by practitioners, but in these circumstances mothers became compliant relinquishing control of their care to healthcare professionals (McKinley 1972; Graham and Oakley 1981). One mother described the outcome for her as '*you surrender yourself to these people*' whereas another commented, '*you just assume that they (professionals) are all right*' (FG5).

Being treated as an object during patient/practitioner interactions has been well documented (Strong 1979; Frankel 1983; Heath 1986) but within this research it was not always a one way process where mothers were passive. In an emergency where mothers feared for the lives of their babies, they initiated an objectification process of their own, intentionally becoming an 'inanimate object' to protect their unborn baby, during an obstetric complication or operative delivery. In an emergency mothers within the study described how their priority became the safety of their baby and their response to over exposure of their body and loss of control of bodily privacy was to disassociate themselves from their body, lying still and inactive in order not to impede the work of professionals. In this way mothers acknowledged they are doing *'the best for the baby'* by reducing interference with treatment or the birth, with the outcome that their privacy maintenance was abandoned.

'Facilitator: It is almost as if you didn't mind what happened?

R Yeh, I mean you wouldn't be too worried about it because you are worried about your baby's safety so you don't care who does what to you, or who sees what, or whatever, you are just happy to go through it and make sure that the baby comes out and make sure that everything is all right.'

(FG4)

'I think it is always different when you have a baby because you don't care what they do to you just get the baby out and get it out safely and quickly and so privacy to a certain extent it doesn't matter... Your privacy, your dignity everything doesn't matter, just get this baby out safely.'

(FG4)

Any issues relating to privacy, such as being viewed or observed, became unimportant and insignificant and sacrificed in order to achieve a safe birth. Mothers described how they no longer cared what happened to them and were willing to endure extensive breaches in personal and bodily privacy and *'whatever it takes to get the baby out'*, in order that their baby was born well. In this way mothers supported the notion of the body as a vessel through which their baby was born and on which practitioners could perform any necessary procedure. While mothers adopted the role of inanimate object, they did however, remain concerned with surrounding events, describing how their senses became heightened during events as they fought to hear for reassuring news that their baby was well. Their ability to participate in decision-making became insignificant to them however, as they relinquished themselves voluntarily to practitioners.

By becoming a voluntary inanimate object within the environment of turmoil associated with emergency operative deliveries or procedures, such as fetal blood sampling, mothers observed what was happening around them almost in the role of a third party or an *'uninvited guest'*.

Scenarios of emergency events were described by mothers within focus groups as states of mayhem with people entering and exiting rooms with little respect for their privacy. For example, one mother described how when her baby's heart beat decreased *'it was like all hell breaking loose'* with people entering and exiting the room. A second mother added:

'I had a very rapid labour and I was monitored because his heart beat was dipping and then they (doctors) had to take a (blood) sample from his headthey have to do their job, they have to keep coming in and out and bashing your door open.'

(FG 3)

When mothers perceived their baby to be compromised they appeared to lose control of their immediate environment. The perception given was of open access to strangers who entered their personal space as a *'welcomed intruder'*.

In comparison to being a voluntary inanimate object, mothers admitted directly to the delivery suite when in established labour described an alternate process which I have termed, self-introversion. Mothers described how on admission they were able to achieve a sense of physical control of their privacy through isolation from other mothers, personalising their room through the inclusion of their own belongings and by having their birthing partner present. Feeling safe and secure in the environment with their midwife enabled mothers within the study to express control over associated events, particularly in relation to pain management. As pain levels increased, privacy was achieved and managed by self-introversion or withdrawal to reduce the impact of intrusions on their ability to manage pain while handing over privacy management to the midwife. This self-introversion was only witnessed within the study where mothers had a normal labour, with no pain relief or intramuscular medication such as Meptid, and without the intervention of an epidural which eliminates pain. Where mothers felt in control of their labour pain they described being able to concentrate on their body and their breathing, resulting in them becoming desensitised to surrounding events and conversations. By doing this they became totally immersed in their experience and therefore unconcerned about their privacy maintenance, including exposure of their body or being viewed:

'You become withdrawn in the other persons mind because you are in a bubble. You

are in your own world and as far as I was concerned it was just me and my husband.'

(FG5)

'I was really out of it. It's you but happening to you rather than with you.'

(FG 5)

Partner I think during the delivery Janice wouldn't have noticed if there had been a coach full of Japanese tourists come through quite frankly (laughter). But you wouldn't have done though (laughter)

Janice: No, I can't remember half the things that I went through.'

(Janice FG1)

During self-introversion restructuring of privacy boundaries occurred in relation to the intensity of pain and in relation to both circumstances in which they are constructed and in relation to individual needs at that time, similar to Fahey's zones of privacy (Fahey 1995). Privacy needs were context-specific and, although during self-introversion mothers were unconcerned about bodily exposure, this was not permanent and changed under different circumstances. Goffman (1961:61) describes this type of situational withdrawal as 'regression' or a 'plateaux of disinvolvement' where:

'The inmate withdraws apparent attention from everything except events immediately around his body and sees these in a perspective not employed by others present.'

Within this research mothers were no longer concerned with events around their body or even within the room, isolating themselves totally from surroundings events. During interviews and focus groups mothers described how they felt during these periods of self introversion as one mother described:

'You feel as if your body is almost detached that you no longer have your senses or your body as one'.

(FG 1)

By psychologically separating the body from the pain, such as that caused by labour or invasive physical examinations, mothers within the study described how the experience became something that happened physically 'to your body' but not personally 'to you'. During this phase mothers within the study described themselves as being in 'a haze' or being 'really out of it':

'I think you expect to have some control over invasion of privacy, actually once you are in pain you don't really care. That's what I feel about it. They could do anything they please to me at that stage because all the sort of normal ideas on what you think should be private goes out of the window.'

(FG5)

'..they kept trying to ask me things and I was in so much pain I could barely even listen to them let alone think about an answer. They would ask me things and then wait for

an answer and I was like just get on with what you are doing. I can't understand you.'

(FG3)

Relinquishing ownership of the body enabled mothers within the study to disassociate themselves from procedures, through what Rachels (1975) describes as '*property rights*', as a coping mechanism and to reduce embarrassment. By temporarily disassociating from the body mothers subconsciously enabled other persons to claim ownership of it, with subsequent right of possession and legitimate access. While Rachels perceived disowning the body as detrimental and disempowering, within this research ownership was temporarily transferred, by mothers, voluntarily to midwives. As temporary ownership was relinquished to midwives, the professionals became the new '*owner*' with right of access to mothers' bodies, enabling them to act on their behalf and address their privacy needs without consent, what Lawler (1991) calls '*an environment of permission*'. Central to this was the establishment of trust between mother and midwife, which once established, enabled mothers within the study to relinquish privacy care to the midwife in order that they could personally deal with the process of labour or self-exposure, as part of what might be called positive disowning of their bodily privacy. The following mothers explained:

'They were more concerned than I was I felt. I was at a point where I just didn't care what happened whereas they were the ones who were covering me over with a sheet when anyone knocked at the door or that kind of thing so it was actually that I didn't have to think about it at all.'

(FG 1)

'I had the midwife and I gave her total control and I said to her, do what you want, what you think is right, I will do whatever. I had total faith in the midwife who looked after me.'

(FG 3)

As witnessed during participant observation, mothers handed over control of addressing their privacy requirements to midwives so that when people knocked on doors or accessed rooms they no longer needed to pull down their clothing, cover themselves, or acknowledge that person, leaving these superficial tasks to their midwife. This reallocation of basic privacy management was not verbally acknowledged between mothers and midwife but undertaken through a subconscious awareness of each other, focusing on the needs of mothers. Mothers were then able to focus on their alternative tasks in the knowledge that they were supported by their midwife.

Being Looked at and Watched: Issues with visual privacy

Another facet of bodily exposure was visual privacy, or being viewed by others. While in voluntary inanimate object or self-introversion states, mothers within the study were no longer concerned about being viewed by others. This changed in relation to the condition of both mother and baby during labour when pain management was no longer an issue. The environment of observation commenced early in pregnancy as mothers were observed by midwives, friends and family. However, on admission into hospital mothers within focus groups described being placed under constant surveillance by midwives in an attempt to monitor their wellbeing. Their perceptions were that the more complicated their birth became the more surveillance occurred from a range of professionals.

Exploration of surveillance outlined in the literature review chapter related surveillance to constant observation by officials usually via cameras, the aim of which is the detection of impropriety (DeCew 1997; Ferguson and Wadham 2003). Surveillance in health terms relates to the use of observation for the detection of deviation from normal health behaviours or patterns (Foucault 1973) and in relation to this research, to observation by both practitioners and visitors:

'I thought as soon as I went into hospital I would go into the delivery suite and I would be on my own, whereas anyone could walk in and out (in the waiting room) and there was me bending over, rocking backwards and forwards doing all sorts of things.'

(FG1)

Mothers within the study described a dislike of being viewed by others while in labour with this influencing the way they felt they could behave. This resulted in them performing how they thought they should, to appease onlookers, rather than what came naturally, such as '*panting*', '*deep breathing*' or '*screaming*'. Mothers felt unable to perform these activities because they were conscious of upsetting or appearing unable to cope, with an associated loss of face in front of others and no more so than when a complication of labour occurred.

An emergency caesarean section can occur at any point during the birthing process and can be classified as an acute emergency or a planned emergency. In an acute emergency the race is on to deliver the baby promptly with minimal risk to mother and baby. In a planned emergency a problem is identified but the baby remains uncompromised; in this instance the time in which to deliver the baby is increased and the experience of mothers within this study was described as '*nice*', '*peaceful*', with feelings of '*time*' and '*safety*'. Alternatively, in an elective caesarean section

mothers were usually booked for surgery well in advance of the proposed birth date describing the process as 'well planned', 'friendly' and 'caring', with a sense of involvement throughout the process. Mothers who experienced an elective caesarean within this study described being treated with respect, discretion and courtesy with an overwhelming sense of involvement for both them and their partner. This created a sense of ownership of, and active participation in, the event, together with control over bodily access, exposure and personal information.

'In the theatre they had it all nice and peaceful in there. The anaesthetist and the midwife didn't leave my side and when she did there was someone else there. My partner was there the whole time. They were chatting to you while I was in theatre and explained what was going on. It was what could have been a traumatic experience they made it like delivery suite bearable....., they treated me like a human being.

(Jessica Interview 1)

'Partner We actually found that there was about 8 people in there but when they were operating you could just see the assistant, the anaesthetist and the surgeon and everybody else moved to the back of the room and only came forward when required so you could only see about two people.

R Yes, apart from (husband) I could only see two other people from where I was lying. They were actually very, very discrete..... It did make me feel a lot better as it didn't feel like I was the show.'

(FG 2)

Even though there were a number of 'observers' within the setting mothers in these circumstances felt empowered, in control and calm, their overall perception being one of being treated with dignity and respect. In an elective caesarean section under controlled circumstances medical staff were perceived by mothers in the study to be in control and more willing to address their privacy needs, with the result that the situation felt more relaxed and parents felt informed. The mothers' rationale for the differences in care during operative delivery related to hospital staff having more time, and where this related to private care, the fact that they were paying and had a choice in what care they required.

In comparison to an elective caesarean section, in an emergency birth the need was to deliver the baby as quickly as possible. In one participant observation encounter I shadowed an experienced midwife in the operating theatre when a mother arrived for an emergency birth. The birth progressed quickly under spinal anaesthesia and the baby was born in good condition. At the end of the operation the mother was observed lying naked on the table with her gown around her neck. Her body was completely exposed and no-one took the time to cover her. In the room was her

partner, the anaesthetist, an operating theatre technician, a midwife, a student midwife and a healthcare assistant. It wasn't until the senior midwife returned that the mother was covered and someone spoke to her. The door to the operating theatre had been open throughout and visitors clearly seen walking along the adjoining corridor. I visited the mother in the postnatal period where she described her sense of shame and embarrassment at being exposed like a 'slab of meat' for all to see, and of her 'horror' of the events. She clearly remembered people walking by and discussions taking place within the theatre, for example, at one point staff were discussing what they would be doing at the weekend. Pre-delivery the mother felt complicit in the process because of the concern for her baby. Immediately following the birth when she knew the baby was safe, she focused on surrounding events, becoming acutely aware of being ignored, both physically and socially, while feeling completely helpless, vulnerable and embarrassed.

'... the whole time I was like 'oh my god' what have they seen? That was quite important to me but of course at the time you don't care too much but you still do, it is still your dignity that's there.

(Interview 1 – Jessica)

Mothers expressed concern about others viewing exposed parts of their body, which were usually out of public view. The idea appeared linked to body parts being viewed by others with the possible outcome that the person might remember what they saw, with the notion of this resulting in embarrassment for the mother at the end of the process.

Part of the concern expressed by mothers within the study was linked to being viewed by healthcare professionals who were not needed within the environment, resulting in a perception of voyeurism. The number of extra people in the room during an operative delivery or examinations was perceived as particularly problematic as the number of support staff and students increased. Mothers felt this process commenced with the introduction of a chaperone and expanded to include doctors, other midwives, paediatricians, nurses, healthcare assistants and operating theatre practitioners, making them question the rationale for their presence.

'It would make you more nervous having someone else standing there. Why bring someone else into the situation?

(FG 5)

'R I actually had up to eight people staring at my bits with my legs up in stirrups and all the rest of it.'

Facilitator: Did you know who all the people were?

R No, no, no, it was horrible.'

(FG 4)

Mothers in the study described how once they had been exposed to observation by a range of practitioners they became resigned to the fact they could do nothing to prevent it during such procedures. The notion of being on display is known to impact on psychological wellbeing of patients (Johnson 1989; Barron 1990) resulting in embarrassment and shame when viewed or observed by others during periods of compromise, including micturition and defaecation (Schneider 1977).

'I was taken to the loo by the midwife and had to sit on the loo and do a wee while she was looking and I was so embarrassed that I just couldn't go'

(FG 4)

During physical examinations mothers within the focus groups were aware of midwives using barriers to help reduce their sense of bodily exposure:

'When you are like that completely naked, you really are exposed ...and even though they put a paper over you and a towel over your knees, you still feel that you are sort of keeping some sort of dignity about the whole thing.'

(FG5)

The idea of having a paper towel over their knees for privacy protection during examinations enabled mothers to psychologically detach their lower body from the total body, with the examination, and its associate touch, becoming something to which the physical body alone was subjected.

Being Grabbed: Inappropriate touch

Being perceived as an object was not just about exposure but also about mothers' sense of their bodies being invaded by touch. Mothers within the study described examples where their bodily privacy was breached by being 'manhandled' by staff, particularly in relation to breastfeeding. Early in the postnatal period mothers described needing to expose their breasts as they attempted to master breastfeeding skills. The international policy for breastfeeding (UNICEF 2001) advocates a 'hands off' approach to breastfeeding by practitioners, however within this study mothers use terms such as, 'rammed', 'shoved', 'grabbed' and 'rough' to describe their experiences:

'..its like every feed, them telling you a different thing. From being very gentle to complete brute force, 'just shove the baby's head on' and you are like 'oh, alright go on'.

(FG 4)

'...the grabbing boob, grabbing the head thing and shoving one to the other'.

(FG3)

'There was one thing that I could take offence to, I think I lost all sense of modesty very quickly in hospitalthe midwife.... she takes your breast in hand and sort of feeds it to your baby.'

(FG1)

'It seems that everyone needs that help to get started on breastfeeding but no-one tells you that is what is going to happen, that someone is going to grab you, so I think that sort of thing should be talked about a bit more beforehand, that most people will find it incredibly difficult and this is how they will help you. Because the help is needed but it is a bit of a shock when someone grabs you like that.'

(FG1)

Mothers within the study explained how access to their bodies was not just open to midwives and doctors; one mother described her experience:

R1 When I had just given birth a lady came in to do some tidying up and I was trying to latch her on (the baby) because they all left me because they were going off shift..... This lady came in and as I said to tidy around and she, the cleaning lady, latched him onto me.

All No. Oh, no

R1 I was grateful but in fact she was really rough, she just came in and said 'oh you want to get that baby on' she just grabbed me and just suctioned me onto him.... And I thought to myself you have probably just had your hands delving around in bins, you have cleaned the toilet or something and now you have got hold of my brand new baby and just tackling my boobs and trying to shove him on there. It is only when you think about it afterwards that you think, that is really bad. But she had obviously done this so many times because it was just, 'oh'

R2 She wasn't an auxiliary or anything?

R1 No, no, no. There's the problem I'll solve that for you I can see what is going on. She didn't even ask me if whether that is what I wanted or anything, she just did it. She was definitely cleaning staff, definitely.'

(FG 3)

Touch is a very personal activity within society and normally women would not expect strangers to touch their breasts unless consent was given. Being in this maternity environment appeared to counteract this privacy strategy leaving mothers feeling open to the touch of others. In the extract above, the mother allowed this stranger to touch her breasts without resistance. The encounter between mother and midwife, healthcare assistant or cleaner appears based around trust and the notion that their intentions are good. As Goffman (1959), Emerson (1970) and Heath (1986) suggest the slightest inappropriate movement of the hand can result in patients (and in this

instance mothers) feeling degraded, embarrassed and violated. During the encounter both participants have competing roles; the mother to master breastfeeding and the practitioner to accomplish this as quickly as possible prior to moving on to the next task (Frankel 1983). It could be presumed that in the incident above, the cleaner acted in good faith with the intention of helping the mother. During such interactions participants (in this case mothers) are more concerned with co-operating with carers to ensure the task is completed (Heath 1986).

Within this study there were two examples of good practice where mothers had positive experiences of touch, with the impression that they were *'offering'* the baby the breast.

'One of the most useful things that somebody said to me is 'you are offering it to him, it is there, if he wants it he will take it' and she made it sound as though I had this precious thing, a normal lady.'

(FG4)

'I don't think the midwife ever grabbed my breast she did ask beforehand and she said 'I need to hold your breast is that all right?'

(FG4)

The language used here is one of *'offering'* based in an environment of trust and consent. These encounters were described by mothers within the study as more supportive and instructive as a means of empowering them to successfully breastfeed their babies, without feeling violated or manhandled. In these encounters mothers were able to maintain a sense of privacy maintenance that enabled them to grant permission to midwives to touch their bodies; once the encounter was completed mothers felt their body remained their own. The two mothers in the above extracts presented their experience of breastfeeding in a positive way using terminology such as *'holding'* and *'offering'* which are less intrusive to their body.

While mothers felt that parts of their body were manhandled, such as when breastfeeding, as if not attached to them, they also described how practitioners invariably held conversations across their body as if they were not physically present.

Conversations Across Me

Another aspect of being perceived as an object described by mothers within focus groups related to the use of electronic fetal monitoring (EFM) of the fetal heart rate (an indicator of fetal wellbeing) which mothers perceived created a barrier between them and carers, with professionals engaging in discussions concerning the machines output without their involvement. EFM has the potential to

be used on admission in normal or uncomplicated births, but is generally implemented on a continuous basis where the baby is compromised (NICE 2001). EFM consists of equipment, including fetal heart rate monitoring and tocolysis (monitoring of contractions), via either abdominal transducers or vaginal based fetal scalp electrodes and intrauterine pressure devices. Either method resulted in mothers being attached to equipment for significant periods of time, more so if an abnormality was detected, when it maybe used continuously. In relation to privacy mothers within the study raised it as problematic when machinery became the foci for practitioners:

'...all these consultants and they were having this conversation around me as if I was just one of the machines you know, 'what we are going to do here, shall we switch it over to this, shall we try that, while we stick that there and see' and on occasions they would turn to me and go (rising an eyebrow) and then they would carry on with their conversation, and you know I was thinking hold on a moment you are talking about me and my baby what is going to happen to me, what you are considering doing to us and you are hardly even including us in this conversation. I think they think you are stupid.'

(FG3)

During one observation two doctors were observed entering a mother's room, leaning against her bed with their backs towards her, they unrolled the electronic printout and discussed the recording with the midwife; at no point were introductions made or an explanation given to the mother. The mother continued to lie on the bed attempting to look around the practitioners to see what they were reviewing. Eventually they turned smiled at her, one doctor placed his hand on her leg, told her *'everything was ok'* and they left. The mother then said *'what was all that about, who were they'* and it was left to the midwife to explain the encounter.

Being talked across or not involved in decision-making disempowered mothers making them reliant on decisions made by practitioners. Mothers' sense of dignity and self respect they perceived could be maintained by talking with them, rather than across them. Mothers' perceptions were that they were not involved in discussions as practitioners perceived them as deficient in intellectual capacity, in relation to pregnancy and birth, as in the data extract above. They initially questioned events but even this minor level of questioning ceased as their level of decision-making declined and they became compliant in interactions (Kirkham 1989). As mothers ceased to participate in social interaction they became objects in encounters, perceiving practitioners to cease addressing their privacy needs (Vail 1966; Gubruim 1975).

In summary, although there was no evidence of the use of the term objectification given by mothers, identification of several well known dimensions of objectification were evident; for example, mothers felt ignored by practitioners, talked across, and treated as if they were not present during some interactions. What is new is identification of the willingness of mothers to handover privacy maintenance to the midwife. This positive objectification was initiated and controlled by mothers to help protect their babies in times of emergency, or in uncomplicated labour as self-introversion for pain management. In an emergency they perceived lying still and not interacting with staff would help reduce any interference with the birth of their baby.

Conclusion

Satisfaction with the degree of privacy offered in maternity care environments was dependent on a variety of factors; these included where mothers were in their pregnancy or early postnatal period, the environment where care was undertaken, the circumstances surrounding pregnancy such as complications, how many other people had access to mothers' environment, their own need to interact or isolate themselves from others and the need for professionals to assess the health and wellbeing of both them and their baby. Privacy is individually specific and unique to the mother being both context and process specific. Therefore each mother may have similar privacy needs to another mother, but because of their own unique prior privacy experiences and the current context in which they are placed, their privacy needs will differ. It is therefore difficult to create a blanket or universal policy applicable to all mothers without considering the uniqueness of their own perceptions of privacy and the context in which they are applied during pregnancy, childbirth and early mothering.

Each stage of a mother's pregnancy brings different challenges for privacy. Early in pregnancy the challenge was to maintain bodily privacy of the abdomen; once desensitised to this low level bodily access mothers found themselves being involved in more invasive procedures as pregnancy progressed, usually culminating with admission to hospital. The environment in which mothers within the study then found themselves varied considerably between home, community and hospital, and also within hospital, and impacted on their ability to achieve the level of privacy which they desired. Mothers appeared to enter the maternity services somewhat naively, with a perception of being able to maintain their current level of privacy and in most cases had not considered this an issue before the point of admission. This was reinforced through individualised

care within the community where privacy was usually not problematic for mothers, where care was offered within small rooms in local accommodation. However, on admission to hospital wards mothers described being largely overwhelmed by the lack of privacy available because of the design and layouts of wards, the number of people (both residents and visitors), and the attitude of some staff. Within this environment their privacy attainment appeared to be influenced by others, both mothers and visitors, either through being observed or listened to. Of particular importance were breaches of privacy caused by the initiation of invasive procedures within public environments such as wards; here mothers found they were subjected to vaginal examinations and procedures within hearing distance of others and while this did not compromise their bodily privacy visually, the thought of others overhearing the details of the examination resulted in an increased sense of embarrassment and in some cases, shame, at its conclusion.

Mothers within the study expressed concerned over the invasion of their private space by strangers with whom they did not wish to socialise, particularly if they felt continuously on show and unable to secure periods of withdrawal from social interactions. Isolation, mothers determined, was necessary not only for their recuperation but also necessary for labour, so that they were not viewed or watched and so they could labour according to their own needs. They expressed concern over labouring in front of other mothers and visitors and wanted personal space through single room accommodation at this stage. Central to this need was the ability to be isolated from others when they wanted and when self initiated, in order to prevent a 'loss of face' or face saving linked to their sense of incompetence and lack of mothering skills or labour proficiency. What they felt embarrassed about was not wishing to be seen as unable to cope with labour pain, or for others to witness their shame in being incompetent as a new mother.

Mothers within the study attempted to manage their privacy through a range of strategies aimed at reducing the impact of privacy loss on the perception of their self. In ward environments mothers reduced the interactions they had with others in an attempt to isolate themselves from their peers, with some mothers in the study declining to interact with strangers. Another strategy adopted was to pull bed curtains around their bed space to isolate themselves from others. Once labour commenced some mothers explained how they requested analgesia early in order to move from crowded wards to single rooms in the delivery suite. This gave them time to unpack their belongings and become acclimatised to their new environment before the birth of their baby. By

creating a sense of ownership within the environment mothers were able to promote and maintain their privacy with the co-operation of the midwife.

Once in single room accommodation mothers in labour used self-introversion to reduce external interruptions by others within the environment. Maintenance of this strategy was dependent on the level of trust and respect a mother had for her midwife and whether she felt they would act appropriately on her behalf in addressing her privacy needs. By handing over privacy management to the midwife mothers were able to concentrate totally on pain management, rather than the task of bodily concealment. Although there was evidence that mothers within the study felt at times they were treated as objects by staff, a second strategy adopted by them during labour was for them to become intentional objects in interactions with professionals. During periods where mothers felt their babies were compromised they acted as objects in an attempt to reduce their impact on the emergency care provided by midwives. At this time they were willing to endure any form of privacy loss if their baby's health was threatened.

There are common factors which underpin aspects of privacy presented within the sections of this chapter. Mothers wanted to remain autonomous and a partner with professionals during encounters, wanting a choice over what happened to them and with whom they interacted. Where they had a perception of being in control of events, their surroundings, the care they required and social interactions, they described a sense of ownership over their body, the environment and their personal information, which, while suspended at times was easy to reclaim later. When mothers suspended their privacy, to include either self-introversion or intentionally becoming inanimate, they still expected to be treated with dignity, respect and courtesy by being involved and informed. If this was achieved mothers perceived the loss of privacy as a temporary sacrifice and a necessary component of having a baby, and as something which would later return. Mothers felt that staff did not address their privacy needs when they perceived them to be incompetent; for example, when attempting to breastfeed or following loss of body fluids in public. Under these circumstances they felt open to privacy breaches which resulted in open access to their body, humiliation or loss of face in public. Midwives therefore, were perceived by mothers to play a pivotal role in their procurement or prevention of privacy and it is their views on what they perceived to be mothers' privacy needs, which are presented in the following chapter.

Chapter 5: Privacy: Midwives' Views

Having presented mothers' views on privacy what is now considered within this chapter is how salient were these concerns for midwives? The questions posed during the research considered: is there a discrepancy between what midwives perceived mothers to require in relation to privacy, as compared to what mothers have described in the previous chapter? Do professional priorities influence midwives' perceptions of privacy needs of mothers? Do these priorities play an important role in their plan of care? This chapter builds upon data obtained from mothers, outlined previously, and acknowledges that as the majority of midwives are women they also have similar privacy experiences as mothers, which in turn are influenced by, or impact upon, their practice. The chapter also draws together data obtained on privacy strategies used by midwives within their practice as they aim to meet employer policies and professional frameworks that identify their duty of care to mothers.

Midwives are lead professionals in the care of mothers during pregnancy, labour and the early postnatal period (WHO 1992). Throughout care provision midwives' priority is the safe delivery of babies, while maintaining the health and wellbeing of mothers. Midwives practice within a range of settings, with the community midwife often the lead professional for pregnant women whereas hospital midwives function as part of a multi-professional team, thus increasing the number of professionals in contact with mothers. Data collected from observations were acquired from a range of maternity settings including GP surgeries, homes, antenatal clinics, wards, specialist clinics and delivery suite.

The four sections in this chapter draw on data from eight interviews with midwives, supported by participant observations. The first section describes midwives' views on physical privacy and exposure of the body, addressing issues relating to physical examinations, being covered and touch. The second section explores midwives' views of the impact environment on the privacy of mothers, particularly in relation to the performance of physical examinations, visitors, accommodation, and access to rooms. The third section moves on to describe the impact on privacy of open access to records, the professionals' right to discuss mothers' personal information, disclosure of information and discussions during physical examinations. The final section explores data obtained on midwives' perceptions of their own privacy and the impact these have on the

privacy care they provide for mothers, giving some notion of underpinning personal philosophies on which midwives base their practice.

Privacy of the Body

As was shown in the previous chapter, during pregnancy, birth and the puerperium mothers' perceptions were that social norms of bodily exposure and privacy boundaries altered, as they found themselves revealing parts of their body, during assessments, not normally within the public domain (Goffman 1959; Lawler 1991). This raised the following questions: do midwives use social privacy norms and their own perceptions of bodily privacy as a foundation on which to base their perceptions of mothers' privacy needs? Do midwives identify and acknowledge the bodily privacy requirements of mothers? If so, then what techniques do they use during their practice, to help mothers' with bodily privacy?

A recurrent theme identified during interviews was midwives' need to ensure mothers had privacy in relation to their body. Midwives described how they covered mothers during examinations, placed notices on doors to prevent access, tried to befriend mothers and their partners as quickly as possible to ensure they were placed at ease, and tried to address, as far as possible within their practice, the different privacy needs required by individual mothers. However, as will be shown within this section it was not always possible to achieve these aims within the confines of current practice.

Management of Bodily Privacy

Exposure of the body, in varying degrees, is usually necessary within hospitals, and more so in the maternity settings where it is essential for the administration of treatment and care (Lawler 1991). Midwives within the study suggested that even though it was a routine component of care, they adapted their practice to provide individualised care to mothers. Once midwives were aware of the level of exposure mothers felt comfortable with, particularly during labour, they claimed they altered their practice, interactions and behaviours accordingly, in an attempt to achieve a standard of privacy tailored to the kind of privacy they perceived mothers required.

Where bodily privacy was discussed by midwives during interviews it was often described as varying, dependent upon personalities of mothers, and based upon their observations of the way in which mothers exposed their bodies during labour:

'There are obviously some women who are quite happy to adopt an all fours position with her bum to the door with no clothes on whereas other women would prefer to be covered up and under the sheets..'

(Gina)

'She had the Winceyette nightie up to her neck and down to the floor.'

(Betty)

'In the pool people sometimes do keep quite dressed, but once they are in the pool they are usually quite happy to be unclothed, but other people are still wearing their long T-shirt..... Again you do always get the odd ones that once they are pushing you actually have to say 'I do need your knickers off'.

(Abigail)

The use of professional experience, midwives discussed, as incorporated into their own practice as a foundation on which to estimate care they thought was suitable for each mother. Part of this experience was included their own inhibitions relating to privacy. Here the recognition of variation was often accompanied by a reminder to set aside their inhibitions:

'She (mother) was like 'I don't want this on' and I will never forget it because it was a real learning experience of actually she doesn't want to be covered up, she doesn't care, she feels safe but there were ward rounds, there were doctors and it did feel as though it was Piccadilly Circus. And there she was (arms out to the side). She was a really big lady as well, but I expect I was putting my inhibitions on her in that I would have been crawling under the blankets.'

(Edna)

'I will never forget I was in a room and one lady, she was a big lady and I tried to cover her up every time someone came in the room, and she just didn't want to. She was (makes pushing away movement with hand) like 'I don't care I am quite happy so don't worry about it dear' and it was just such an automatic, 'oops don't know who this is going to be' cover you up again....'

(Edna)

'You have to be very careful that you are not just thinking about your own views of privacy in relation to how these women feel.'

(Fran)

The midwives in these extracts identified the transposition of their own inhibitions relating to privacy onto mothers, considered the privacy needs of mothers in relation to current circumstances and conditions, their own privacy ideals, perceptions, experience and ideology, as the following midwives explain:

'You just have to think about how you would feel in that situation (being watched during examinations). I know that I wouldn't like it and I'm sure that women don't.'

(Edna)

'I wouldn't want to be standing talking to someone without my knickers on and I'm sure they (mothers) don't either.'

(Abigail)

Midwives in these circumstances, considered good practice as them acting as advocate for mothers' privacy needs based on their own experiences relating to the body, and in particular bodily exposure. This is reflected in a common phrase cited by midwives during interviews where they recommended treating *'mothers as they expected to be treated themselves'*.

The need to cover mothers, midwives legitimised during interviews as stemming from taking cues from mothers, and from previous experience of people entering rooms unannounced. They described their aim as to reduce bodily exposure and intrusions of bodily privacy by covering mothers quickly when intrusions occurred. Midwives described adopting a privacy management role by covering mothers, which was supported by mothers within the study as necessary so they could manage their pain without needing to worry about others witnessing their bodily exposure. In order to ensure that mothers' privacy from being viewed by others during exposure was minimal, midwives outlined the techniques they adopted to ensure mothers' bodily privacy was protected during labour, or when visitors entered rooms:

'You have to cover mothers, they don't want to be seen with their bums in the air, so you just have to cover them when someone knocks.'

(Helen)

'They just need to be covered when people come in as they (intruders) don't think and just barge in.'

(Cynthia)

Covering mothers during intimate examinations was perceived by midwives during interviews as a necessary component of good practice. One midwife described two techniques associated with the procedure:

'.... (it) depends on how people actually do VE's in that are you someone that takes all the sheets off or are you someone who folds the sheet back up so that they are covered at the top bit and you can just flick it down to the bottom if someone comes in.'

(Helen)

The ideal approach, suggested by midwives within interviews, was folding back the sheet used to cover mothers, creating a division between mother and 'procedure' or between mother and midwife, as midwives considered this enhanced mothers' sense of dignity during the process.

Within this study viewing of mothers' genitalia by non-professionals was perceived by midwives to compromise mothers and therefore had to be kept to a minimum. As one midwife explained:

'You just have to make sure that everyone who shouldn't be in the room at that time is asked to leave, otherwise they just stand around and its not nice for mothers when they want to labour with their clothes off, because they just end up starring at their bits waiting to see the baby arrive.'

(Edna)

To be seen without clothes and under the gaze of strangers was something that midwives felt compromised mothers' privacy (Goffman 1961; Goffman 1963; Kelvin 1973). Exposure of the genitalia, as shown in the literature review (Chapter 2), is associated by psychologists and sociologists with vulnerability, degradation (Arendt 1958; Westin 1970; Schneider 1977; Lawler 1991) and with personal compromise (Kelvin 1973). Removing unnecessary people from the room, midwives argued, helped to ensure that they reduced any sense of perceived voyeurism experienced by mothers. By reducing observers, midwives felt mothers could concentrate on the process of labouring, without being concerned about visual intrusions from others.

Although midwives in the study placed emphasis on the need to cover mothers in order to ensure bodily privacy, there was one event witnessed during my observations (described previously in Chapter 4) which involved a mother who was left naked on the theatre table, without any apparent acknowledgement of her bodily exposure by the staff present. After observation of this I was in a position to interview the student midwife, midwife, healthcare assistant and operating theatre practitioner, regarding their role in caring for the mother. Not one of these people identified a problem with the care she received immediately post operation, or acknowledged the level of exposure she experienced. It was as if it could be assumed that by not acknowledging the mother's nakedness, they did not have to address it, or consider it as within their practice. Although this was the only incident of its kind I witnessed during the research it raised questions relating to the skill of staff and their professional 'blindness' in the care of this mother and why this event occurred?

One argument proposed by mothers within the study was that midwives adopted a production line mentality when working in ward environments, which they felt increased midwives' over familiarity with bodily exposure and perpetuated professional 'blindness'. This was supported by interview data from midwives where they confirmed their desensitisation to, and over familiarity with, bodily exposure:

'I think it is familiarity that you get used to the environment of women without their clothes on and we don't think anything of it and we forget what it is like initially and what it is like on the other side. Sometimes it is just simple things like a student covering someone up which makes you think, oh, I should have done that.'

(Gina)

Midwives appeared aware of practice standards for bodily privacy required by mothers but sometimes suggested that it needed a colleague or student to revitalise their awareness of care and remind them of the standards to be maintained. They suggested working with students to remind them of the need to address bodily privacy by bringing their practice back to 'basics' (Lawler 1991), and considered the standard of privacy care provided as linked to personality of practitioners, as the following midwife described:

'I think some of it is just people not thinking (not addressing privacy)..... I think it comes down to personalities doesn't it. You have people that think of basic nursing care (privacy care) or those that don't and sometimes they need to be picked up on it.'

(Doreen)

Midwives within interviews, linked the personality of practitioners to bodily privacy initiation and maintenance and whether staff were considerate enough to consider this aspect of care. In practice this was determined by midwives to be defined as *'achieving a satisfactory level of care'* for mothers. Midwives agreed that privacy management was basic to their care, linking it to practical skills, such as covering mothers and shutting doors, rather than associated with higher level professional skills and competence.

Following the observation cited above I was able to later meet with the senior midwife to discuss the event. I asked her why she felt other people in the room had not seen the mother's predicament:

'Because I suppose I could put myself in that situation, the last thing that I would want is to be laid on a theatre table exposed to the world who is walking past and I think that is quite important to me. There is a physical privacy but there is also the other part of privacy, which is enabling the woman to feel comfortable in whatever environment she is in.... sometimes midwives don't think about what is happening around them as they are more worried about what they are doing (caring for baby in this instance) than taking in the bigger picture.'

(Edna)

Not only did this midwife function as a higher level practitioner (Benner 1984) by dealing with the mother's immediate post-operative care, she also saw her level of bodily exposure and addressed

that simultaneously. Although data cannot explicitly explain privacy stages in midwives' professional development it is suggestive of a breadth of privacy stages, ranging from skills based privacy (where the aim is to complete tasks), to privacy 'blindness' caused by desensitisation and overexposure, to a higher level practitioner able to consider all aspect of care including privacy. However, what is not known from this research is, how do midwives move forward from the desensitised stage to the expert or higher level practitioner stage, and does this occur in all midwives? However, fundamental to midwives' practice is the need to observe mothers in order to assess fetal and maternal wellbeing, which subsequently has implications for mothers' achievement of bodily privacy.

Observing Mothers

Something else that compromised privacy was the need to directly observe mothers, described by midwives during interviews, as a component of their '*duty of care*', required for monitoring wellbeing of mothers and babies. Midwives were aware of their statutory requirement to monitor and assess mothers and their babies. However, with the current shortage of midwives and subsequent increased workloads, they described how they ended up multitasking within ward settings, resulting in them having to observe mothers without actively *being with* each mother, describing conflict between this duty and adhering to the values of privacy. Midwives' described needing to directly view mothers, particularly when mothers were compromised in some way, because they were not able to provide them with individual attention. Since there were so few midwives in the clinical environment because of current shortages, the need to directly view mothers at a glance appeared to have become more critical. This meant that mothers, who had normal births, requiring minimal observation during the postnatal period, were subjected to the same high level of observation by midwives, as higher dependency mothers who were post-operation. In a busy, production-line environment, a standardised approach to care becomes dominant, with professionals need for medical gaze overriding individual requirements (Foucault 1973). Midwives described moving quickly through wards, glancing at mothers rather than undertaking an individual review; therefore, they perceived mothers could never achieve privacy from visual intrusion as their need to observe overrode their personal requirements. Two midwives accounts made this very clear:

'We would try to save beds nearer to where the midwives were going to be, its nothing to do with the women more to do with the midwives' observational need..... our role is to over look them all the time, so there is conflict between perhaps their needs and our needs.'

(Fran)

'You can't really change that observation thing. With the 25% caesarean section rate, we have got so many women who are first and second day sections that perhaps we need to observe, for at least the first twenty-four hours when they need more help. You need to observe, drips, drains, dressings etc a bit more closely, women with more devastating antenatal conditions that extend into the postnatal period,trying to differentiate between those and those that have had normal births, there could be conflict'.

(Doreen)

Thus, tension appears to exist between midwives' ideal of 'being with women' versus their duty of care to observe them; even where midwives were unable to be with women they were aware that their duty of care remained. One compounding issue, which clearly made observation 'on-the-move' impossible, midwives within interviews suggested, was mothers' actions of drawing curtains around their beds. Here one midwife explained her concern:

'I have been in situations before where the curtains have been pulled round somebody that was having an induction of labour with potentially dangerous results, because you can get called away to do other things, whereas if you had full view of the woman and the monitoring process then I would have perhaps picked up on something much sooner. I had to make a physical effort to go to the bed and look.'

(Fran)

Mothers' use of bed curtains increased midwives' anxieties at not being able to observe all mothers in keeping with their duty of care. It was the view of midwives within interviews that the needs of the midwife and of mothers were therefore in direct conflict here and ideally what was required was 'proper facilities' such as smaller occupancy rooms and 'sufficient midwives to be able to get round and observe everybody adequately'. While midwives expressed a need to professionally observe mothers they were aware that other people were also observing them, such as their partners.

Partners Observing Physical Examinations

While midwives felt they had a professional duty to observe mothers they were aware of current trends for partners to remain during mothers' physical examinations. Physical examinations are an inherent component of assessments undertaken by midwives during labour and usually consist of less intrusive abdominal examinations, to more intrusive vaginal examinations and diagnostic procedures. Traditionally in nursing, visitors were asked to leave while body care or invasive procedures were performed (Lawler 1991). However, in direct contrast in midwifery the drive has been to enable partners to stay with mothers throughout labour, and this now includes remaining while assessments are undertaken. Midwives described how in some cases they perceived

mothers not to want partners to stay during examinations, suggesting that partners felt 'trapped' or 'captive' and unable to exit.

'And there are husbands these days, and that goes back to privacy because all women want their husbands to be there all the time (for the birth). Its fine when they are delivering but there are quite a lot of women who don't want their husbands there while they are having a vaginal examination or fetal blood sampling.'

(Gina)

In the past observing mothers during these procedures was seen as, voyeurism, and perceived as unnecessary for partners involvement in childbirth (Alexis 1986; Alderman and Kennedy 1997).

Some of the midwives interviewed felt partners should be given the option to leave prior to examinations, arguing that they remained because of social, peer and partner pressure, which today requires men to stay to experience the process of childbirth, with their partner, irrespective of circumstances. This added a conflict of interest for midwives between meeting mothers' birth plans, which included partners being present throughout, and maintaining the privacy of mothers, while ensuring that partners did not compromise their privacy. Midwives felt mothers wanted their partners at the birth, but perceived them to be too nervous to tell them not to stay during intimate procedures; therefore midwives, adopted strategies through which to ensure that the needs of both mother and partner were assured, as the following midwife explained:

'Ok, you could say a vaginal examination is part of that process but there is no end result at that particular time and sometimes you have to intervene in that, it depends on how well you know the woman and what sort of relationship you have built up because it is sometimes easier for you to intervene in that process in that you say to the woman 'do you want you husband here or should I throw him out?' sort of thing and I tend to say that in quite a jocular way, if I know the woman. Because it is easier if you make that decision rather than the woman saying, because I think she feels embarrassed for her husband at having to throw him out and embarrassed for you as well because I don't think she feels that is what she should be doing.'

(Gina)

One method suggested by midwives during interviews was to address this issue and gain consent early in the midwife/mother relationship, so as to ensure consensus across all parties:

'That is up to ..midwives to make sure they always ask consent and offer them (mothers) that option. It is also something that I would have thought would be quite useful to do when they are first admitted, is that you are going to be doing intimate examinations and do you two actually want to discuss whether you want to be here (the partner), or for you to be given the opportunity to go. So at least you know where you stand.'

(Abigail)

Midwives wanted to give mothers the option to let partners leave prior to intimate examinations, as they perceived mothers to feel embarrassed during examinations when partners were present. However, data collected from mothers did not identify this as an issue. The perception of midwives was that partners did not want to witness these procedures with mothers not wanting them present either, with both feeling obliged for partners to remain. Midwives' therefore perceived their role was to ensure that both parties discussed this prior to labour so they felt comfortable with their partners' presence, thus reducing any sense of embarrassment or shame and enhancing bodily privacy.

Touch and Its Role In Privacy

Touch in relation to privacy is linked to two concepts identified by midwives within this study: firstly, the public's fascination with pregnancy and the social need for people to touch mothers' 'bumps' and secondly, midwives perception of legitimised touch, seen as necessary for the assessment of mothers and babies. During interviews some midwives described their perception of the public's fascination with pregnancy that facilitated individuals to touch mothers; the fascination appearing to be with the 'bump' and not the mother herself. One midwife explained:

'People do invade their personal space; they (the public) are always touching women that are pregnant, touching their bumps. I can't understand that, why do they always want to touch a pregnant woman?'

(Cynthia)

During interviews midwives argued that this form of social interaction helped mothers become desensitised to physical contact by others. In society there are social boundaries associated with the body that involve etiquette relating to touch (Goffman 1963; Heath 1986). Social touch is inevitable as we come into contact with each other, particularly in crowded environments. However, social touch does not incorporate contact with genitalia or breasts, particularly in women, as these areas are perceived as prohibited unless in intimate encounters (Jourard 1966; Jourard 1967; Jourard and Rubin 1968; Frankel 1983; Lawler 1991). However, observations and discussions with midwives within the study regarding therapeutic encounters, such as between midwives and mothers, highlighted how they viewed their touch as a legitimate diagnostic tool and so it was interesting to note that they considered themselves extraneous to this social touch process.

The level of physical contact midwives had with mothers, they argued within the study, was limited to physical assessments such as abdominal and vaginal examinations or support with breastfeeding, which they did not classify as physical intrusions of the body, but as a professional

necessity. The national breastfeeding policy offered by UNICEF advocates a *'hands off'* approach to breastfeeding (UNICEF 2001) aiming for mother and baby to create a bond through breastfeeding with minimal physical intervention. However, there were incidences given by midwives within the study where touching mothers were not perceived as helpful and went against this national policy, as the following midwives explained:

'Facilitator: Are there issues then relating to handling of breasts in breastfeeding then?

Abigail: Well if they read our unit policy on breastfeeding they will know that they shouldn't be doing that.

Facilitator: Yes, I gather you have a hand's off approach?

Abigail: Yeah. I mean again its that business about permission to touch someone else's body and just because you are in a hospital you shouldn't just presume that you can do itI think people will make the assumption that it is quicker and easier rather than try to explain.'

(Abigail)

'People just touch don't they? Like the breastfeeding woman and there is a lot of touch isn't there? Normally it is hand's off someone else isn't it?'

(Cynthia)

'I went to visit a particular woman following a visit from this other midwife and she said 'I don't want her in here again' and she has gone (gestures grabbing her breast).

(Doreen)

Midwives within interviews suggested it was often easier for some colleagues to have *'a hands on approach'* rather than explain to mothers what needed to be achieved. This was supported mothers within Chapter 4 who described being *'grabbed'* by midwives during breastfeeding. There was consensus by midwives within the study, however, that permission to touch should always be sought during this type of encounter:

'Sometimes I feel that we probably do need to touch but I say, 'do you mind if I do this?' I wouldn't even dream of going up and doing that. You know when your boobs are full of milk they are so painful. It is bad enough if you are touching them yourself let alone someone else.'

(Doreen)

Permission to touch the body was described by midwives as inherent in privacy care, although there was some acknowledgement that colleagues (not themselves) did not always acquire consent to touch prior to encounters. Inappropriate touch, particularly in the form of grabbing, can feel like a violation of the body and a breach of bodily privacy, and so consent becomes invaluable when associated with sensitive touch (Heath 2004). Midwives' right of access to physical contact with mothers' bodies during pregnancy was perceived by them as intrinsic to their role and a

component of care needing little acknowledgement, which was developed through building a relationship with mothers.

The Role of Relationship Building In Privacy

An additional theme identified by some midwives within the study was the need to create a friendly relationship with mothers as quickly as possible during their interactions in order that bodily contact, which breaches usual privacy norms, could be made and physical assessments take place. Although discussions with community midwives during observations suggested they created good relationships with mothers, as they had contact with them over a greater period of time (which reflects data within Chapter 4), it was hospital based midwives meeting mothers for the first time during labour who described the need to create a trusting relationship as quickly as possible:

'I think there needs to be good communication between the woman and I mean like we were talking this morning about whether or not you have continual care throughout with the same midwife. In an ideal world that maybe the best situation but we don't live in an ideal world so it is up to you to try and build up a relationship with that woman as quickly as possible..... I think it is having an understanding of what the woman's needs are.'

(Fran)

It would appear that midwives meeting mothers for the first time during labour felt somewhat disadvantaged in comparison with their community colleagues because they lacked the friendship and trust they had developed with mothers in their care. Trust has been documented as a component of a professional/client interaction (Curtin 1986; Lawler 1991) which, if achieved, enables patients to feel supported during physical examinations. Midwives suggested that a relationship could develop quickly between midwife and mother through midwives' understanding of mothers' needs, supported by trust and good communication. However, two midwives within the study took an opposite view; they described how they felt being unknown to mothers actively promoted and enhanced mutual respect and trust, thus ensuring bodily privacy could be achieved through keeping a 'professional distance'. One midwife explained:

'The thing is people trusted their doctors, they thought they were wonderful and if the doctor said that the room was black then the room was black. It was respect. The ward sister was called Sister and never by the first name. It has gone really crazy hasn't it? It is over familiarity.'

(Cynthia)

Professional distancing was perceived by some midwives within the study as necessary to deal with the intimate nature of their practice and to distance themselves from mothers to ensure a reduction in mothers' feelings of embarrassment during examinations and helping them feel

relaxed during encounters. Whatever their view, midwives' were aware they needed to rapidly gain the trust of mothers, either through professional status (as in the extract above) or earned, because of the need to perform physical examinations without mutual embarrassment or shame.

In summary, this section has shown that midwives thought each mother should have their own individual needs addressed, and in practice based their care on their own anticipation of mothers' bodily privacy needs, rather than identifying their needs directly with mothers. Throughout admission to hospital midwives wanted to achieve an acceptable level of observation of mothers within the busy ward environment to ensure they met their duty of care. Midwives within interviews also perceived mothers to express a lack of concern over physical privacy, and so felt compelled to act on their behalf to ensure privacy needs were not compromised. They related privacy to basic care skills such as covering mothers, providing professional touch and gaining trust through good communication, yet in practice they appeared to become blind to these activities as reported by themselves and mothers.

The Environment of Care

Midwives find themselves practising in a range of environments which differ, both between and within sites, and therefore they have to be adaptable and responsive to environments in which they practice. The previous chapter outlined how mothers entered hospital and were overwhelmed by the open environment and the role it played in their privacy attainment. This section turns to midwives' assessment of this familiar environment and addresses the questions: how do midwives perceive the ward environment to impact upon mothers' privacy and what role do midwives perceive personal space to play in achieving privacy for mothers? Do midwives perceive they have a right of entry to mothers' personal space, and if so, why? This section reviews privacy in relation to the environment of care in which a midwife practises her art and contains data relating to midwives' perceptions of privacy needs of mothers in relation to such issues as personal space, the impact of visitors and the right of access to mothers' living space.

The Impact of Environment on Privacy

Mothers' impression of the hospital environment shown in Chapter 4 was one of high occupancy, where interaction with other mothers and visitors was inevitable. Their views were associated more with occupants than ward layout, whereas midwives perceptions of the environment concentrated on layout and issues relating to its use as a work environment. The challenge described by

midwives within interviews was the maintenance of mothers' privacy in the public space of hospitals, whilst acknowledging the setting as a public work area. One midwife explained:

'I think because of the anatomical layout of the maternity unit there is huge difficulties in any shape or form of offering the type of privacy that perhaps some women would like.... The numbers of people, the turnover and the activities that are going on doesn't allow them, or facilitate them to have any privacy whatsoever, even for the most basic of functions. It is different in the labour ward, because they have their own private room but on the open ward areas absolutely none at all.'

(Fran)

Ward environments are designed for high occupancy and ease of access for staff, with the aim of creating an efficient and effective workplace for staff (NHS Estates 2002); however the latest drive by the Department of Health is the provision of a '*healing environment*' which stimulates the five senses (sight, smell, touch, hearing, taste) to enhance recovery through a stimulating and homely environment (DH 2006). Some midwives described in their interviews how they felt facilities which enhanced homeliness were gradually being eroded from the environment, in direct conflict to this recommendation:

'We have just got rid of ours (day-room). We had nice coffee machine and snack machine with seats and tables in it and they gutted the space. They wanted more bed space. I don't think there was much foresight into some of the changes that have gone on. It has made privacy issues much worse.'

(Fran)

Instead of mothers moving out of sleeping accommodation during visiting or for social conversation over coffee, the lack of space, midwives suggested, has forced them to entertain themselves or their visitors by their beds, thus increasing the number of visitors in contact with all room occupants, and the perception of overcrowding and privacy intrusion. This reflected the views of mothers within the study where they suggested it was virtually impossible to rest or sleep within this type of environment when high numbers of visitors were present.

Overcrowding and Visitors

Midwives within the interviews considered wards to be overcrowded, reflecting the views of mothers presented in Chapter 4. Most maternity units within this country now offer open visiting which midwives reported resulted in visitors staying for prolonged periods during the day, creating a working environment for midwives where the number of room occupants was greatly increased. Midwives described how visitors congregated around individual beds, which were already too close

together, giving the ward the sense of being significantly overcrowded. Two midwives described their views:

'It is not only a place for the woman to be but a working environment for the midwife and in some of the places where I have worked, the working environment for the midwife is so compact and overloaded with people that it becomes an overbearing environment, exhausting and overbearing for the people that are working there, so what it is like for the women I have no idea, it must be three times as bad.'

(Edna)

'Six beds, six women, six babies, if it was a postnatal area 3 visitors, if you manage to keep it down to three. I think I worked out once that you could have well over one hundred people in one ward at one time during visiting hours. That is a huge amount of people. Each individual woman, quite rightly sees their birth and their baby as an individual and don't necessarily see what is going on around them. They want their friends and relatives to come and see them, when they want to see them, and they don't think about what else is going on. They are only thinking about their own needs.'

(Helen)

What midwives described were two competing agendas, one where midwives perceived the environment as a place of work and a place in which they had a job to complete and secondly, a social environment where mothers expected to receive visitors to celebrate the birth. Excessive overcrowding was perceived by midwives during interviews as problematic within wards, particularly during visiting times, making working conditions undesirable and challenging, while decreasing the level of privacy they could secure for mothers. Midwives argued that mothers and visitors became self-centred after the birth, no longer considering the requirements of other occupants, the drive being for mothers to 'show off' their baby to their visiting relatives, irrespective of difficulties other mothers maybe experiencing:

'This open visiting where you have all and sundry coming in, any time of the day, is not necessarily the best thing for the woman and the baby, in the long run. She may not view it that way.'

(Helen)

This speculation that mothers did not like visitors was echoed by mothers within the study where they described how they were happy to interact with their own friends and relatives, but not with anyone else's visitors and were relieved when visitors departed at the end of the day (see Chapter 4).

Recuperation of mothers following birth was perceived as essential by midwives during interviews and the intrusion of visitors was not perceived as conducive to that recovery, mirroring more

traditional views on the need for seclusion for mothers following birth (Spacks 2003). The overall consensus by midwives during interviews was that mothers who were well enough to entertain visitors should do so at home, thus reducing intrusions for those mothers whose conditions were compromised. The rationale given was that mothers could more readily monitor visitors entering their own home, whereas in hospital they were open to visitors irrespective of their needs, particularly as midwives considered they had little control over monitoring these intrusions. Midwives within interviews considered mothers' need recuperation to be dependent on their ability to reduce intrusions by the acquisition of personal space.

The Need for Personal Space

An emerging theme during interviews with midwives was concerned with their recognition of mothers' need for personal space even though they were aware that it was unlikely that it would be achieved. Mothers within the study wanted personal space within hospital in which to labour and bond with their baby and partner as a new family. Midwives, on the other hand, recognised that mothers needed space but were aware of the realities of working in a spatially challenged environment. Within busy wards where space was at a premium, midwives perceived mothers to lack the ability to secure their own personal space, finding this difficult to achieve in the type of accommodation available. One midwife explained her view:

'Mothers want to have their partners with them after the birth, they want to be together as a new family and have a cuddle and talk over what happened and sometimes just to sleep together, but they can't do that in the wards as there isn't enough room, they're just crammed in.'

(Helen)

Midwives described how they felt mothers and their partners needed personal space to be together as a new family post-birth to cherish this unique time. Part of that time they suggested was for parents to display affection towards each other without fear of being viewed by others:

'The majority of pregnancies are planned and therefore this is a moment in their lives where it is only those 2 people ...you know they may be quite an intimate couple who perhaps feel embarrassed, to perhaps give each other a hug or a kiss in front of a complete stranger. They want some space for themselves. ...There are some couples who don't care and they will be all over each other and you will find them lying together on the ward bed. After the delivery I think that is very important to leave them alone.'

(Edna)

Open displays of affection in public places are discouraged within society as in conflict with social norms (Goffman 1963; Altman 1975; Pandiani and Banks 1998) and this is no different within

maternity units, where intimate contact between parents is not encouraged in open wards, even though this is a period of intense emotions for parents.

Although some maternity units had single rooms these were usually small in number and rationed by midwives to more 'needy' mothers, such as mothers with stillborn babies or those with babies in special care baby units. Even this proved difficult as one midwife explained:

"Well when you look at the caesarean section rate of 25% and one side room, how do you allocate a side room to one person?"

(Abigail)

During interviews midwives described how they perceived mothers now sought admission earlier in labour than was traditional. While no explanations were offered by them for this phenomenon, they suggested it compounded the shortage of space, if mothers were subsequently admitted:

'They come in far too early and expect to be in labour and to stay on labour ward; just because you come into there doesn't mean that you're in labour and its really disappointing then to be sent home or to the ward. The wards then fill up with mothers who should be labouring at home.'

(Cynthia)

Historically mothers would have remained in the privacy of their home, being assessed by their community midwife, until the advanced stages of labour when they would have presented directly to the delivery suite. Midwives explained how early admission resulted in an increase in mothers utilising the available space and with the move to shared ward accommodation, rather than an antenatal/postnatal divide, has resulted in mothers being allocated to rooms where there could be antenatal or postnatal mothers. This proved problematic for midwives when attempting to manage the available space:

'We could have people in early labour but we try not to, the aim was to keep them all in one particular area. We try not to (mix them with other mothers) because we recognise that women who are in early labour do need to have a much quieter personal space to get on with the job.'

(Gina)

While midwives acknowledged the special privacy needs of mothers in labour, which was supported by data from mothers within the study, they found it increasingly difficult to achieve these needs within the constraints of wards. The answer to this difficulty, midwives suggested, would be to redesign accommodation to meet users' needs, particularly as old communal style wards no longer appears to be meeting the needs of today's mothers. The standard design for maternity

wards in this country is four to six bed rooms with shared ward toilet, evolved from the classic open ward design known as the Nightingale ward, where beds ran parallel to each other along oblong shaped rooms with occupants facing each other. Although there is a move to re-structure wards to smaller occupancy rooms, the internal design and layout of beds remains the same (DH 2001d; NHS Estates 2002). The original design of wards promoted face-to-face contact between mothers as they faced each other, promoting social interaction for those who were in bed for significant periods of time, however in maternity units mothers stay between six hours to four days (following operative deliveries or antenatal complications) creating an environment where turnover of occupants is in a state of continuous flux. During one observation encounter midwives were seen allocating mothers on the basis of reasons for admission. However, as the turnover of mothers increased during the day these good intentions were quickly thwarted by lack of bed spaces available in the necessary areas.

Mothers within the study spoke negatively about socialising with other mothers, preferring to be isolated from social contact, reflecting current social norms for privacy, which promote self or family isolation (Bailey 2002; Scott and Keates 2004).

'Now people don't want to be social. They actually don't want to talk to the person in the bed next to them. That's where I think there is a culture change.'

(Doreen)

This was in direct contrast to midwives' perceptions of mothers' needs where they promoted communal ward living as a means of enhancing learning about mothering and for the creation of new friendships.

'Its good for mothers to be into together, they get to talk about their babies and what is happening to them and this helps them learn about breastfeeding and caring for their babies'

(Gina)

'Mothers should be in together it helps them create a bond. They are all in it together. They end up making friends which they keep when they go home.'

(Doreen)

Social interaction of mothers within wards was perceived by midwives as part of mothers' developmental process of becoming a new mother. By not interacting there was a perception that mothers were missing out on peer learning and self-support networks, which midwives considered vital to the development of their new role as mother.

While midwives within the study considered communal living in wards as suitable for mothers they expressed concern over lack of personal space for fathers trying to acquire solitude from their partner's labour, a concept that did not emerge during focus groups with mothers. Midwives described how if fathers wanted personal time, they directed them to 'temporary' accommodation on the delivery suite, such as, waiting rooms:

'We haven't got anywhere where perhaps husbands who don't directly want to be sitting in the room for whatever reason with their wife, at that particular time, there is nowhere else for them to sit except in the mothers' room. We are trying to restrict that because it is very restricting for the mother who wants to mobilise. She doesn't like sitting in a room with one man sitting there on his own.'

(Edna)

Midwives were aware of the poor facilities for men, which resulted in them using rooms usually occupied by mothers in early labour because of a lack of separate waiting rooms. These waiting rooms were perceived by both midwives and mothers within the study as public places, where it was inappropriate for mothers to be sited while in labour and even more so if lone fathers were present. This resulted in partners ending up 'wandering' around delivery suites, enhancing the potential for the occurrence of inappropriate intrusions.

Right of Entry

Mothers' personal environment or space, midwives within interviews considered, was open to intrusion by others, both professionals and non-professionals, because of a perceived right of entry. While mothers within the study discussed entry into their environment by practitioners in terms of unnecessary intrusions, or alternatively, as a necessity during emergencies, midwives discussed entry in relation to professional right of access in relation to three concepts: access by senior staff wanting to be kept informed of mothers' conditions, the hunt for controlled drug cupboard keys by staff and the plain '*ignorant*' or those not wanting to abide by normal social etiquette.

Midwives regard themselves as professionals in their own right, practising autonomously and not professionally accountable to senior staff as in nursing (WHO 1992). This means that midwives work independently and as such are directly accountable for their actions to the Nursing and Midwifery Council (NMC 2004b). However, the ethos within delivery suites described by midwives during interviews was for senior midwifery staff and obstetricians to adopt a supervisory role to monitor practice. One midwife explained:

'They are allowed to come in regardless, I think that's always the answer 'I am in charge and I need to know what you are doing'. 'No you don't because I am responsible for what goes on in here and I shall inform you.'It is almost like they are immune. There is a culture within delivery suite that the registrar, the anaesthetist, the consultant doing the round, they have right of entry over everything.'

(Betty)

Midwives described how ward rounds had been reintroduced with each mother visited by the obstetric team and a senior midwife at least once during labour, increasing the number of intrusions to which mothers are subjected. This resulted in groups entering mothers' rooms usually without permission being sought, moving away from the promotion of birth as normal to that of obstetric intervention and monitoring (Hunt and Symonds 1995; Symonds and Hunt 1996). This form of monitoring appeared to be taking place much to the annoyance of midwives, who suggested that it impacted on mothers' privacy by increasing the level of intrusions to which they were subjected, and also impacted on their own practice as they were constantly expecting intrusions and surveillance from others. Even though the midwife may be professionally accountable for her actions the need to promote professional autonomy was seen as inherent to privacy maintenance by midwives; where midwives were not autonomous they could not prevent intrusions occurring. Where midwives were not able to enforce autonomy then other professionals appeared to gain right of access to their working environment with the outcome that mothers' privacy declined and intrusions increased.

Given this right of entry to rooms, midwives in the study described the steps they took to secure privacy in the environment:

'Everyone still feels that they have the right to go into that shut door. If you really want to make it private you have to put a big sign up and have to go around telling everyone to stay out.everybody who works there seems to have right to walk in. Even visitors seem to think they have a right to walk in as well. So if you want to make it very private you have to shut the door, go around telling everybody to stay out of the room and put a big do not enter sign.'

(Betty)

The following midwife explained her role in ensuring privacy for mothers who were exposed:

' The midwife should be there to protect the woman so that if somebody knocks at the door then she should say 'hang on a minute' because there are members of staff who knock and walk in and that should not happen.'

(Gina)

During interviews midwives described how individuals within the environment, both professionals and visitors, appeared oblivious to normal social etiquettes such as knocking on doors and waiting for permission to enter. They felt knocking appeared to offer no more than advanced warning of entry, and was not an attempt to gain consent to enter. In discussion with a senior midwife, she explained how she felt staff had to be *'strong willed to knock on the door and just wait there'*.

Midwives described how in an attempt to control visual privacy for mothers from intruders, interior curtains had been introduced around doors, so where access was gained visual privacy was maintained:

'I would hope that they don't actually come into the rooms as we have the privacy curtains round, they should always be round, so that even if people are actually coming into the room they should be stood behind the curtain.'

(Abigail)

In reality, midwives described how even with these curtains drawn, other staff entered rooms and opened the curtains before talking to them, even though in the majority of circumstances the information required was not relevant to room occupants and viewing mothers was unnecessary.

While midwives felt they and their colleagues should take control in these circumstances, they felt it was dependent on the strength of character of the staff member. One midwife explained:

'I think they either take those issues on board (privacy) or they won't. It depends a lot on personalities. I think sometimes they just don't think. They are not use to it and they just don't think at all.'

(Abigail)

Normal social etiquette was highlighted by midwives, during interviews, as often forgotten by their colleagues within the delivery suite, with their professional need to know what was occurring, overriding the privacy requirements of mothers.

One of the commonest causes of intrusions into rooms cited by midwives was *'looking for the keys'*. Each delivery suite has a set of controlled drug keys which are held by the midwife in charge and acquired by colleagues as analgesia was required by mothers. After use the keys are supposed to be returned to the key holder in readiness for the next acquisition:

'You should use the keys and give them back. If whoever is leading the shift knows that they are going to be tied up doing a VE or helping someone with an epidural top-up she should give them to someone else and perhaps there should be a note up blah de blah has

got the keys. I have always known that they go back to whoever is running the shift and then if they don't, you need to know who has got them.'

(Cynthia)

One midwife described her view on the keys in relation to privacy as:

'The keys are more important than what is going on in your room'

(Helen)

Senior staff used the keys to legitimise access to enter rooms to observe events. The outcome of this activity however, was an increase in intrusions for mothers, known to disempower patients and reduce their respect for practitioners (Allekan 1973; Magnusson and Lutzen 1999), and was a sense of annoyance and erosion of professional autonomy for midwives.

Within the study the general consensus of midwives was that the environment played a significant role in both mothers' and their own ability to achieve and maintain their privacy, which was compounded by the provision of care within a busy, ever changing and financially driven setting. Midwives considered the environment as a place of work, where intrusions and constant observation were common, social etiquette in decline and where privacy was difficult to achieve. They believed mothers considered the environment as a place of temporary accommodation, where they could be visited by friends and relatives according to their own personal needs, but where midwives felt partners' privacy was neglected. Within this environment both mothers and midwives felt powerless to prevent intrusions by others, including other midwives and doctors, resulting in them feeling unable to maintain mothers' privacy.

Disclosure Privacy

As was shown in Chapter 4, mothers' felt their personal information was disclosed during physical examinations and ward rounds, as well as through eavesdropping, or simply by overhearing conversations. This posed the following question, did midwives perceive mothers' personal information was being disclosed and how? This section presents data relating to midwives' views on conversations between professionals and mothers, disclosure of information through discussion of conversations or cases by professionals, and discussions between professionals during examinations.

Conversations during Examinations

Both mothers and midwives described how practitioners held conversations across mothers particularly during intimate examinations, without engaging them in the discussion. Midwives within

interviews recalled their own experiences of, being talked across during examinations when a patient, of doctors talking across mothers during examinations and conversations undertaken between doctors and trainees during intimate procedures, to highlight their perceived privacy or dignity loss in mothers. Midwives considered it disrespectful for doctors to engage in conversations across them or mothers during procedures, describing how it reduced their sense of self-respect and integrity, and influenced their ability to protect their privacy. While they discussed this in relation to doctors, it is worth noting that they did not consider themselves guilty of similar actions. The outcome of a lack of interaction with professionals was considered by mothers to be professionals ignoring them during encounters (see Chapter 4), which was mirrored by midwives when they drew on their own experiences as patients. One midwife explained:

'I can remember having a smear taken and they had left the speculum there and he was fiddling around and talking and doing this and I was going (look of horror) 'excuse me'.

(Doreen)

In one incident a midwife described how a mother had a speculum left in place *'while the doctor had to take a phone call'*. In addition, it was often the 'banter' that went on between male doctors and partners during vaginal suturing such as, discussing football results or the size of the perineal tear, that midwives found most dehumanising, degrading and disrespectful to mothers:

'It is worse when it is the husband to the male doctor because they then go 'ha ha' about it and that is really awful.'

(Abigail)

By ignoring mothers, midwives felt practitioners were able to perform difficult examinations on mothers' bodies without experiencing embarrassment or compunction in the loss of privacy (Vail 1966; Lawler 1991; Applegate and Morse 1994; Misago *et al.* 2001). However this was interpreted by mothers as practitioners ignoring them or treating them as *'stupid'*. Moreover, there were no incidences within the data though of midwives intervening in the process or acting as advocate for mothers during these events.

Disclosure of Personal Information

Mothers within the study were aware that their personal information was being openly discussed in a range of forums within maternity settings and while this caused them some concern, generally they accepted this as part of the process of admission to hospital. In comparison, midwives within interviews highlighted violations of disclosure privacy occurring through ad-hoc discussions at nurses' stations, through information documented in midwifery records, through their presence

within a setting, either during midwives' visits to homes or via mothers visiting antenatal clinics and through the discussion of cases while at work. While the level of information disclosure varied, midwives expressed concern that whatever the cause, the outcome had the potential to be detrimental to mothers.

During interviews midwives displayed concern that verbal disclosure of information occurred in open areas around nurses' stations, mirroring concerns expressed by mothers. Midwives explained how nurse's stations were generally congregation points for staff within wards and places where both professional and social conversations occurred:

'They are dreadful (nurses' stations). You can't have a telephone conversation without people in the bed nearest to you hearing every single word that you are talking about. There are no other offices or any other space where you can go and talk on the phone or privately to a client, family, doctors or anyone, so I am sure there are breaches in confidentiality all over the place in that ward. Disgusting it is. There have been complaints where women have overheard members of staff talking together.'

(Helen)

I was party to one such event during an observation in the ward area, where I arrived at the nurses' station and overheard midwives and doctors discussing the case of a suspected baby with Down's syndrome. They continued to discuss the case in detail even though I was unknown to them. It was almost as if I was invisible and therefore not overhearing or participating in the conversation. I felt angry with them for revealing this personal information regarding the mother, and for discussing this case in a public area, thus putting me in the position of hearing it.

While open discussions in public areas were a source of privacy breach identified by midwives, midwives were also aware that client-held records carried by mothers had the potential to disclose personal information as they not only included a detailed history of their pregnancy but also their past medical, obstetric and social history, which is considered when assessing the safety of mother and baby. While mothers in the study were relatively unconcerned about people accessing their records or their content, midwives during interviews felt mothers were pressurised into revealing their personal details, which they in turn felt obliged to record:

'The number of times you will hear people say, 'oh I had a termination but I don't want that documented' and I am amazed what women will tell you. They will tell you all sorts of things and then they are desperately anxious that they don't want anyone else to be able to

have access to that information, so I say don't tell us in the first place. That trust is quite phenomenal.'

(Abigail)

Midwives in the study believed mothers to be unsure as to what private information was important to their pregnancy, which resulted in them revealing anything they considered remotely important to ensuring the health of their baby. They suggested mothers felt blackmailed into revealing information to them in case anything went wrong with their pregnancy, which could then be attributed to something in their past. Midwives spoke of how they offered mothers advice regarding inclusion of information before disclosure, which reflected data obtained from mothers, to ensure they were informed of the consequences of data being available to others:

'Your partner should not have access to them (records).... if they are in an abusive power situation and (the partner) chooses to look at those notes, unless the woman can actually stop him from doing that then he has access to it.... if they are in a situation that they have disclosed information that they don't want their partner to know then again that is very difficult.'

(Helen)

This is supported by a data extract in Chapter 4 where one partner stated that he had accessed the records of his partner without her consent, although she had not appeared concerned regarding this. In circumstances where mothers disclosed confidential information which they wanted to remain private, such as previous pregnancies not known to their partner, then midwives within the study described how they introduced complementary records in keeping with their trust policies, in which subsidiary information was documented (DH 1997b; DH 2003):

'We had a scheme where a dot was added to the mother's records to let other staff know there was other information which they need to know about; it is a sort of code which only the staff know about'

(Doreen)

While midwives within interviews felt disclosure of information could occur when individuals read mothers' records, they also described how it occurred inadvertently during casual discussions:

'You can get caught out can't you? You are just wafting along on a conversation...'

(Cynthia)

Confidentiality was considered by midwives to be a learnt response required for professional practice. However, because of the casual and friendly interactions midwives have with mothers they felt they could be drawn into disclosure, during 'chatty' discussions, without realising. Doreen explained in her interview how she had inadvertently revealed details of a pregnancy to a mother she was visiting. When discussing homebirth with a mother she advised her to discuss this with a

neighbour who had one previously; however during the discussion she inadvertently revealed she had visited the neighbour recently, informing the mother of her neighbour's pregnancy.

While disclosure of information mainly occurred through records and conversations, two midwives within the study also revealed how disclosure could occur by the mere fact that they were present in the environment:

'We had one recently (birth which needed to remain confidential), she actually did not consent to sex and her partner wasn't from the same ethnic minority so she has had to keep it from her family, we've been going in out of uniform and we had to be sensitive obviously. It is very hard. It's about being adaptable to the individual. You have to be.'

(Edna)

The presence of midwives within the community, particularly where distinctive uniforms were worn, revealed to neighbours the reason for the visit. This was the same within hospital clinics where the trend was to mix antenatal and gynaecological patients:

'.. calling out names is actually disclosing who's there. Especially now when we have mixed gynae clinics, so you can have a fertility clinic going on and an antenatal clinic going on. You don't actually know who is for what, but you know which clinic you're for and if someone is going to a different clinic if you happen to know what that clinic is, I mean it hasn't got up fertility clinic or terminations or anything like that but you can guess.'

(Abigail)

The potential for disclosure of purpose was identified as real and occurring even though the chances of this happening were considered as rare by staff. Midwives felt that mothers needed to have confidentiality assured if they are attending for termination of pregnancy or infertility treatments and in some instances early pregnancy, as they felt mothers wanted control over release of this information.

Discussing Cases at Work

Reviewing cases is central to the professional development of midwives and should occur within an environment of confidentiality (NMC 2004a). The desire for personal space at work, in which to review difficult cases or to have a gossip on a 'good tale', was cited by midwives during interviews as important to their practice. During participant observation I came across a group of delivery suite midwives within their allocated coffee-room discussing a case in which one of them was involved. The discussion was informal, included aspects of the mother's progression and care, and included the use of humour to hide the midwife's uncertainty of her practice; however it occurred in an environment where other people were present. The following midwives outlined their experiences:

'They still probably wouldn't say some things in there (coffee room) because they know it is the coffee room, whereas if they are in a different environment where privacy is maintained and perhaps there is an air of confidentiality..... that would enable them to be open and free to discuss whatever they wanted.'

(Helen)

'... if a group of midwives were looking at reviewing a case or something like that then if I was leading that in that situation then I would try and find a room which would enable privacy to be there so that the conversation could be honest and open and they didn't feel that they were being listened to or watched and they felt confident. It is somewhere they feel comfortable and not exposed.'

(Edna)

'It is the type of cases but also the type of person probably as well because there are some people who need to talk... There are others who like to spill the beans and then forget about confidentiality and don't care whether it is in a private place or not and there are others who are halfway in between. I think it depends more on the individual. It is what they feel comfortable with. I would perhaps look at cases and review them with a midwife in the coffee room provided there was perhaps no blame or no criticism, but if I was going to look at a case and there were learning needs for the midwife, then I would take that midwife to a more private setting so as not to embarrass her and knowing that she could say what she wanted to say to me and vice versa really.'

(Edna)

'Midwives always refer to 'my lady' it is like an unwritten rule that you never use names, dates, times, places but you have to talk to somebody about it and no-one at home is the least bit interested in your lady, so you go and find another midwife. You are checking it out 'have you had anything like this, is this unusual and what did you do' and 'oh my goodness I have never seen anything like that before.'

(Betty)

The perception of midwives in interviews was that information discussed within coffee or staff rooms, used for informal learning, did not constitute a breach in informational privacy (Hunt and Symonds 1995); here the need for privacy from colleagues, within their team or shift, was not deemed a priority as long as the conversation was not overheard by anyone else. When formal discussions of cases were necessary, midwives described them as being undertaken in an area where confidentiality was assured for both midwife and mother. Alternatively, disciplinary or educational discussions, where there were criticisms or concerns over midwives' practice, midwives were convinced would take place in environments where confidentiality from others was assured.

Midwives argued that the need to discuss practices within their professional group, enhanced camaraderie and group solidarity (Bolger 1985). In this way small social groups were formed within the workplace enabling midwives to gain a local support network which they perceived helped them ensure that privacy was maintained both for themselves and for mothers' cases. By being a member of the organisation or professional group, midwives' suggested ensured members followed implicit institutional or professional privacy guidelines often referred to as organisational privacy (Westin 1970; Bloustein 2003). In this situation, any discussions were perceived as only relevant to the group and of no concern to others therefore, could be discussed anywhere:

'You go to the Christmas party and eventually after a couple of hours the only thing you have got in common with all those people sitting around that table is work and so you end up discussing work.'

(Edna)

Group camaraderie enabled midwives to talk about their work in public places, moving the conversation away from their personal lives, thus maintaining their own personal privacy boundaries, and ensuring they had a sense of belonging to the conversation.

In summary, disclosure privacy was described as occurring in open ward spaces, through documentation of information in client-held records and during discussions across mothers during intimate examinations. However, midwives' discussions in the workplace were not perceived as central to breaches of privacy as they perceived them to be within their control and with colleagues who they considered would not disclose the information to a third party. This section highlighted the significant level of disclosure not made public to mothers, which midwives regarded as important to their own professional development. Although disclosure of personal information was important to midwives within the environment, the following section addresses midwives' views on privacy in relation to their professional boundaries offering some idea of the personal philosophies which underpin their practice.

Midwives' Perceptions of Self Privacy

At the start of each interview midwives were asked for their personal view on privacy, in relation to their own experiences, as a means of engaging them in conversation early in interviews. This resulted in data on midwives' personal views on privacy in relation to confidentiality of personal details, and their own need for personal and professional boundaries. These data were important to the study as they showed midwives' perceptions of privacy in relation to both themselves and their

profession, which they incorporated into their practice as a foundation for determining the privacy needs of mothers. The following questions were explored in relation to this section: Are midwives concerned about disclosure of their own information at work? How do midwives define their own personal and professional boundaries and do these boundaries impact on mothers' privacy?

Confidentiality of mothers' personal information was deemed central to a midwife's practice (NMC 2004a) by midwives in the study, but was also important for both mothers and midwives within their daily lives. While mothers in the study were concerned with personal information being disclosed to others, midwives identified two issues with disclosure. Firstly they were concerned that colleagues may disclose their personal information to other colleagues and secondly, their personal information maybe made available to mothers:

'(My idea of privacy is) Being able to talk to someone (colleague) and be able to know that conversation is not going to be discussed by anybody else unless you give permission, of course.'

(Cynthia)

'But I think I can say that I never discuss my personal life that is mine. I don't think they (mothers) need to be saddled with that though. They may ask you have you got children and have you got a family..... then it is up to you how much you divulge to them.'

(Doreen)

Maintaining confidentiality of personal information is central to many privacy debates (Badzek *et al.* 1998; Rylance 1999; Petchey *et al.* 2001; DH 2003) and essential to controlling exposure of personal information concerning who we are. Literature in Chapter 2 showed that when personal information moves into the public realm it becomes difficult to control who has access to it, or its use in defamation of character (Chilton and Berger 1999; Bloustein 2003). Both mothers and midwives within the study needed to feel control over their personal information, deciding when, with whom and what to disclose. Where there was little control over withholding this information a sense of personal exposure and intrusion resulted (Young 1978; Deshefy-Longhi *et al.* 2004), undermining integrity and confidentiality (Bolger 1985). Having a sense of control over information concerning them, by ensuring only information they wanted released was placed into the public arena, facilitated midwives' sense of control over their own affairs and to some extent control over information circulated about them (Westin 1970; Parker 1974; Rossler 2005) thus enhancing their perceived sense of dignity maintenance. This debate over release of personal information

appeared asymmetrical, with mothers information deemed as important to acquire, while midwives wanted to build mother/midwife relationships without sharing any of their own details.

Dignity is a term that is generally discussed in association with privacy in healthcare environments (NHS Executive 2000; DH 2001a) and was expressed as important by midwives within this study in relation to exposure of their own personal details. One midwife stated:

'It's about maintaining dignity; the dignity of the person or of information and what's going to be done with it really.'

(Abigail)

Maintaining '*dignity of the person*' in this extract related to disclosure and dissemination of personal information whilst at work. Once information passed into the public domain midwives within the study agreed there was little they could do to retrieve it and this they perceived made them vulnerable to local gossip, breaching personal and professional boundaries. There appears to be a dichotomy here between midwives suggesting it is alright to discuss mothers' personal information within the workplace, but not for midwives to discuss other colleagues' information.

Personal information, midwives within the study agreed, should remain within their control, as confidentiality of personal information enhanced positive segregation of their professional and personal lives, helping to ensure they were viewed by colleagues as professionals. By actively promoting a distinction between work and home midwives were able to '*switch off*' from practice and revert to their private home life, clearly drawing a demarcation line between the two environments in order to protect their personal identity and integrity. Midwives in the study separated their home life from their work to ensure withdrawal from the role of midwife and a move into a private role at home. Intrusions into personal boundaries at home they felt increased through the use of technology such as telephones, emails and texts making them more easily accessible outside of the work environment, clouding the public work/private home divide (Reiman 1995; Klein 1997; Nesson 2001; Peacock 2001). Two midwives explained their privacy boundaries:

'It means a lot of things to me, like when I am off sick, I don't expect everyone to know why I am off sick. I don't expect everyone to barge into the changing room when I am getting changed. I don't expect everyone to start phoning me up at home and discussing the off duty and they can't find this and they can't find that, because it has nothing to do with me, that's my space..... What's going on with my privacy has nothing to do with them (work). The seven and a half hours I am here you can ask me anything midwifery and I will deal with it, outside of that time it is my time, my space and go away. I need to manage it that

way because that's how I manage stress. I can cope with most things if you throw them at me in the seven and a half hours and I can try to be a nice and polite person but I can't be it 24 hours a day. So I can go home and scream and do what I want when there is no one else around.'

(Betty)

'For me privacy is somewhere where I can go that I can be safe in the knowledge that I won't be disturbed. I suppose we think about the basic functions of life where you want privacy, and I suppose you develop your home in that way but you have parts of your home that offer that privacy. Actually I am quite hot on privacy... I would say that I have a great need for my own personal space, but sometimes that works to your detriment because I find that perhaps I push people away and I become very lonely.

(Fran)

It is interesting to note the importance midwives placed on the need for personal space and although they acknowledged its importance for mothers it does not appear to be given the same importance within the study.

Midwives within interviews identified the most common form of privacy breach as being contacted at home by colleagues during rest days. Part of the need for personal privacy at home was the need for withdrawal from others, anonymity and the separation of social identity between work and home, with the aim of reducing intrusions and maintaining privacy boundaries for midwives (Westin 1967; Schwartz 1968; Schuster 1972; Henderson 1975). Maintaining personal boundaries through creation of personal space at home in which to relax and define ones self was important to midwives, as the following midwife explains:

'I don't want people to see me in certain ways of being. If I have guests in the house then I find that I cannot relax in the same sort of way that I would normally do..... I definitely would not be seen in my curlers. I am not the sort of person to go out into the garden in my dressing gown. I have to be seen in a certain sort of way; I recognise that.

(Fran)

Midwives could be described as having a public 'face' used to portray themselves to colleagues and a private face which helped them define who they were (Goffman 1959; Goffman 1963). In order to function in the public world a public persona is developed, as would an actor on a stage, to enable a number of roles to be played within society (Burke 1945; Arendt 1958; Goffman 1959). Midwives appear to move freely between many roles, such as mother to midwife, or mother to wife, with a role or 'face' for each. It is this level of personal freedom within private actions, that creates a sense of privacy achievement (Arendt 1958; Bloustein 2003). In comparison, mothers within the

study described the role they played as new mother within the maternity environment, keen to create a 'face' of being a 'good' mother to present to other occupants, for example, by trying to manage their pain in front of others and not appearing incompetent when learning new skills.

Conclusion

Privacy, this set of interviews seems to suggest, is fundamental to midwives' practice and is seen as inherent in basic midwifery care. Midwives within the study recognised the differing needs of mothers and the need to build relationships which were essential to mothers being able to expose themselves for intimate examinations and procedures. In relation to privacy of the body midwives described how, as they became familiar with bodily exposure, this impacted on the way in which they offered mothers privacy care.

In order to help mothers achieve privacy midwives identified a number of concerns that impacted on their practice. Midwives were aware of the need to work within professional boundaries and policy guidance and of their duty of care to protect mothers to promote safe delivery of their babies. Therefore privacy should not conflict with this agenda. Fundamental to their concept of safe midwifery practice was the need to observe mothers, which midwives reported was becoming increasingly difficult in light of the reality of staff shortages, layout and design of wards and an increase in the number of operative deliveries being performed, which increased the length of stay in hospital.

Midwives' perception of the very public environment of care has affinities with that of mothers. Like mothers they bemoan overcrowding and loss of space, felt wards were too small, badly designed and became overcrowded with visitors. However, midwives identified the ward environment as a workspace which had to be managed and found practising in this setting increasingly difficult. While midwives showed sensitivity to the meaning of the momentous event that is birth, which parents wanted to share with visitors, they found their presence compromised their practice. The number of visitors in wards created problems for midwives both with continued observation of mothers and for issues relating to health and safety; their levels of anxiety at not being able to offer mothers what they perceived to be a satisfactory standard of care at that time, appeared to conflict with their role of ensuring the health of mothers and babies. While mothers did not want to be around other mothers in early labour, midwives tried to ensure that mothers in similar midwifery situations were

placed together within wards to help with observations. However, this was not always possible or sustainable because of the high turnover of occupants and pressure on staff to accept new mothers for admission. Mothers within the study wanted their visitors to attend when they wanted them, whereas midwives considered the overcrowded environment to affect relationships between mothers and partners, where they were unable to offer them privacy in which to act affectionately towards each other at a very emotional and life changing time.

During interviews, midwives described how mothers were subjected to repeated touch by friends, family and colleagues, whom they considered desensitised mothers to being touched in preparation for care during labour. This was in contrast to the opinions expressed by mothers where they felt desensitisation occurred through repetitive examinations performed by midwives. Midwives perceived their touch to be of a therapeutic nature, inherent to their role, and therefore non-invasive.

While it might be assumed that both mothers and midwives bring the same social privacy norms to the environment, such as not wanting their bodies to be open to view, in practice this is only to a limited degree. In addition to social norms were midwives' individualised privacy norms unique to them; for example some midwives may be comfortable exposing their own bodies in public or to healthcare professionals during therapeutic encounters and may use these views to underpin their practice. There are professional privacy norms identified through policy documentation or benchmark statements (DH 2001a; DH 2003; NHS 2003), such as closing curtains, reducing embarrassment and shame (Audit Commission 2000; NHS 2003), which interestingly enough, were not discussed by anyone within the project. These guidelines create standards of privacy care within which midwives are required to function. However, what is not addressed through these standards is the confounding factor of pregnancy. If privacy is operationalised through these social or professional norms then care mothers receive may not be appropriate for them within the context of pregnancy and birth.

The concepts which appear to underpin their views on privacy relate to consent, control, trust, professionalisation, transposition of privacy from midwife to mother and the need for demarcation between work and their home life. Midwives described how they considered their role in privacy achievement to be linked to supporting mothers by taking control of their needs while in their care

and gaining consent to touch prior to each professional encounter, where the body could become privacy compromised. This meant that underpinning practice was the need to develop trust and a good relationship with mothers. However, midwives were also aware that during their journey from new midwife to experienced practitioner, they moved through a process where they became desensitised to mothers' privacy needs. In order to deal with this process midwives needed to separate their home life from work so they could have periods of privacy in which to recuperate before returning to practice, but sadly they do not extend this approach to care to mothers.

Within midwives' data there were new areas of privacy that emerged which were not addressed by mothers; for example, the role of partners, midwives not being able to control entry to rooms to protect mothers, and midwives' need to discuss cases to learn from their practice. Midwives were able to describe the standards of privacy they needed to offer to mothers but focused these in relation to barriers to implementation within their model of practice. They clearly saw one-to-one midwifery throughout pregnancy and birth as the foundation for ensuring mothers had a level of privacy they desired, but were realists and unsure if this was achievable in today's midwifery environments, where the drive is to provide care within a busy, ever changing and financially driven setting. Within this chapter the views and perceptions of mothers' privacy have been presented; the next chapter outlines perceptions of student midwives, who as will be shown, act as a bridge between the views of mothers and midwives thereby offering an alternate perspective.

Chapter 6: Privacy: Students' Views

The previous two chapters presented mothers' and midwives' perceptions of privacy and the impact these perceptions had on care mothers received. This chapter is based on data from eight focus groups with sixty-seven students, plus participant observations. The chapter outlines the views of students in relation to mothers' privacy within maternity care environments and midwives' actions in relation to privacy care they offer to mothers. The questions posed during data collection were: what do students think mothers consider important in relation to privacy? How do they relate these perceptions to their practice? What other experiences do they use to underpin their practice? As students work closely alongside midwives, what are their perceptions of midwives' practices in relation to privacy? What are their perceptions of midwives' attitudes towards supporting mothers in achieving their privacy within the maternity services?

This chapter is divided into three sections: the first outlines students' perceptions of how mothers feel about being exposed, viewed or photographed, having people present during intimate procedures and dealing with body fluids or functions. The second section relates to students' perceptions of environmental privacy, to include, access to facilities, knocking on doors, right of entry, overhearing conversations or talk, mothers being viewed by visitors and the differences between having a baby at home, as compared to hospital. The final section outlines data on professional issues relating to privacy, such as, students' views on their own role, the impact of workloads and other issues relating to their 'job'.

Students' perceptions of the needs of mothers' privacy were linked to their past and present practical experience, which in the case of short course students, included their previous experience as nurses, and for some three year students, as healthcare assistants. In retrospect it would have been helpful to have collected data on the length of time these students practised as nurses or healthcare assistants, to determine the impact of this on their perceptions of care. However, this was not undertaken. Some demographic details of students were collected prior to focus groups, for example 52 students were mothers (78%), the majority were over 26 years of age (82%), and all bar one, were female. These data were collected at the start of the project, as it was presumed they might be relevant, however on reflection the data was of little importance as it could not be applied to individual focus group members. What was evident was that students had a diversity of

experience which underpinned their practice and through which they interpreted actions and events. Of particular relevance to this study were their experiences as mothers, of being with women throughout pregnancy, and their perceptions of care family and friends received when accessing maternity services.

Student midwives are in a unique position in practice, witnessing both the actions and practices of midwives, while observing the actions and experiences of mothers. As will be shown students draw on their own experiences, both as mothers and users of maternity services, relating these experiences to their encounters with mothers. Their challenge is to gain skills as a midwife and come to terms with their new professional requirements, while acting as observer of practice. Students bridge the gap between mothers and midwives drawing on different experiences and perhaps are the most revealing of the three groups, as they try to reconcile two worlds for themselves, while questioning and challenging the existing practices of both groups. Students therefore, provide data from both the perspectives of mothers and 'soon-to-be' midwives.

'Women with their bits and bobs everywhere'

This section presents data relating to students' perceptions of how they perceived mothers' privacy to be influenced by being viewed or touched by others and the tactics employed by both mothers and midwives to ensure that privacy was achieved. The questions posed relating to this section were, what prior experiences do students consider mothers bring to their pregnancy and how do these impact on care they receive? How do students consider mothers feel about being viewed during periods of physical exposure? Are mothers objectified by staff and if so, what impact does this have on mothers' privacy? Do students help mothers achieve privacy within maternity settings and if so what strategies do they adopt?

Shyness and Dignity

Students, within focus groups, often perceived mothers as shy on admission to hospital suggesting this impinged upon the level of control they exerted over care they required. As with mothers, in Chapter 4, students perceived them to be naïve and shy regarding bodily exposure prior to pregnancy, considering that as mothers became more exposed and professional touch increased, through assessments during pregnancy and birth, their sense of privacy was eroded:

'Before they started they may have been really, really shy about their body and you know physicals like, but by the time they get to the end of their pregnancy they think I can't give a

dam any more, because every Tom, Dick and Harry has been there looking at them, so you know they lose it'

(Year 1, 3 year, Group A student)

This was supported by one male student's wife's experience:

'My wife was desperate that at first no-one was going to see her and as time went on she became less and less bothered by it.'

(Year 2, 18 month student)

According to students, mothers' experiences of pregnancy varied depending on multiparity, with experienced mothers (in terms of pregnancy) appearing rather blasé in relation to bodily exposure and physical examinations. The following student relayed her own story:

'I found it very difficult with my daughter, I was sort of 21. Rounds were coming round with doctors and this group of students and I thought, not me and I went off to the toilet and hid. But once I got to my fourth one, I thought yeh, yeh and I was completely blasé about it, so I think it is about how you cope with it on a personal level, what you are use to and what you expect as well. I mean when I was going through (hospital) I was being examined, they put this speculum up and the doctor said, 'do you mind if I bring my students in, this is excellent, I was like oh my God! And I said yeh all right then and there was all these (students) but if that had been done to me at 21 I would have been like 'No way'. You're not all coming in here to peer up my bits.'

(Year 1, 3 year, Group B student)

In this extract, the student implies that when she was younger her degree of perceived control over who viewed her body was enhanced. However, the more children she had the more immune to this activity she became. There are two issues emerging from this discussion, firstly a perception that privacy boundaries change as women mature both in age and multiparity, and secondly, the perception that being younger enhances the ability to control bodily access. The latter was not reflected in conversations with mothers as they perceived themselves to have very little say over who accessed their environment and subsequently, who viewed their body, irrespective of their age.

While age and multiparity were perceived by students to be important to privacy, it was when students felt mothers had control over their situation, such as where birth was perceived as a natural process, that it helped create a positive outlook on privacy maintenance, by promoting a sense of normality throughout. One student described her own experience:

'I didn't feel like I had lost my dignity when I had my children, even though you know all those things I just think that it is a natural process. You have got to do it.'

(Year 1, 3 year, Group C student)

The idea of pregnancy and birth as a normal process appeared to enable students, as mothers, to feel in control of events and of their dignity. However, students echoed comments on loss of dignity made by midwives in Chapter 1, where they were heard to say mothers 'left their dignity at the door' when discussing the birthing process, suggesting that dignity loss was temporary:

'That's what a lot of women say 'oh I will collect my dignity on the way out, pop it in the post to me.'

(Year 2, 18 month student)

Repetitive physical examinations emerged as a theme in relation to dignity and privacy loss. Repeated, and in some instances, unnecessary exposure within the institutional setting, was suggested by students as the cause of mothers losing their dignity with subsequent desensitisation to events. Where students perceived mothers to accept the notion that overexposure of their body to others was inevitable, they felt mothers suspended their dignity needs until the birthing process was completed. During the birthing process, students implied that mothers no longer cared about concealing their body because of the large numbers of people viewing who had viewed them naked or exposed.

Being Viewed During Bodily Exposure

While midwives dealt with mothers' bodily exposure by covering them and acting as advocate to reduce the number of people in the room, students felt unable to protect mothers from intrusion or constant gaze, and presented the view that rather than acting as advocate, midwives instigated, perpetuated, or supported intrusions. Mothers not only have to contend with exposing their bodies during pregnancy and birth, but subsequently with other people viewing them in that state. One student drew on her own experience as a mother to explain how she felt when in a similar circumstance:

'That's just reminded me of something when I was having J and I was being sutured, it was like something out of the X-files. It was like, three or four men came in with white coats and they were all peering up my fanny while he was suturing and I sort of thought, who are these people, what are they doing with me? No-one explained who they were and no sooner had they come, than they were off again.'

(Year 1, 3 year, Group B student)

One student reported a discussion regarding visual privacy she had with her midwife:

'She (said) 'oh she (the mother) doesn't care she doesn't even notice' and I thought 'how do you know?' She might look back and think 'oh my God, there were three ambulance people there, and a GP and two midwives and they all saw my bits but at the time she doesn't care, but afterwards she might really care and that's something you see a lot.'

(Year 1, 18 month student)

The perception expressed by this student was that mothers no longer cared about their privacy during labour and in some respects this notion was supported by the findings presented in Chapter 4, where mothers suggested midwives acted as privacy advocate to protect them from breaches in privacy. However, as shown in Chapter 5, for midwives to act as privacy guardians they must be astute enough to pick up the cue and act upon it. Although mothers in the study perceived relinquishing their bodily privacy was within their control, while concentrating on their pain, students saw midwives as custodians of this control as one student explained:

'I think privacy in this sort of situation is also about control and its about as a midwife you are prepared to let your woman have the control that she needs to have the baby in the way that she wants and that's respecting her rights and her needs and her wishes, which is privacy to some extent, if she is quite happy to have her mum and dad in there and boyfriend, then you've got to go with the flow and you have not got to make her feel awkward about that.'

(Year 1: 18 month student)

Students generally considered midwives to have power of control over mothers' experiences suggesting that if midwives were happy with what mothers wanted during labour, then they would facilitate its achievement. In relation to partners being present during labour, students thought partners' should be part of the process of childbirth, but were concerned that they were often asked by midwives to view mothers' genitalia during labour to promote involvement in the birth. The debate focused on gaining permission from partners and their perceived poor outcome if this activity was not carefully managed. Students considered the process by which informed consent was obtained played a major role in whether or not viewing took place. Where it was conveyed positively and as something of benefit then students felt it was difficult for partners to refuse to participate; students also considered fathers felt obliged to follow midwives' instructions because of their role of authority. One student relayed her own family's experience:

'R1 My dad, he tells me this, that he was actually asked to look and he never forgot it and he wouldn't see me be born because he had seen my brother.

R2 But if you're asked to look, you are not demanded to look.

R3 No you're not demanded to look but it is suggested.

R2 But you are prompted aren't you and you think, oh I should.

R1 My mum didn't want him to look but she wasn't at the point where she could say 'oh no don't', because she was pushing the baby out.'

(Year 1: 18 month students)

As birth is such a unique event this maybe the only time another individual has of witnessing the experience. Therefore gaining informed consent from mothers for partners to view their bodies was stressed as important by students in maintaining mothers' sense of privacy. In order to address this, students suggested viewing should be discussed with parents prior to the event so that consensus of agreement could be reached and consent obtained. One student described her view:

'I think the woman if she wants him to see that, she should say have a look and the midwife shouldn't be telling him to come and look.'

(Year 1: 18 month student)

The reasons for not involving partners in viewing genitalia were summed up by the following student:

'It is more a feeling that the bits that are on display the husband might have only seen them as being sexual, for sexual reasons and now its all sort of ripped to pieces and all over the place and everyone's had a look and a feel.'

(Year 1: 3 year Group D student)

However, there was no evidence within this research that this was of concern to mothers or midwives in relation to privacy. It could be that during focus groups mothers were still too early in the puerperium for this to be an issue, or alternatively they could have felt inhibited in discussing it with a stranger.

Partners were not the only people able to view mothers' genitalia during pregnancy. Students provided data where other birthing partners were also involved:

'I was in with a lady having a Ventouse delivery and her mum was in there and she was constantly looking over the drapes at what the doctor was doing and going 'oh, look at all that blood' which I felt was unhelpful. She had made it very clear that she was not actually with her daughter, she was having a good old look at all her daughter's bits and what was going on down there and that to me was quite odd.'

(Year 1: 3 year Group D student)

In situations such as these, students considered the voyeur's behaviour as unusual or 'odd', and suggested that on reflection mothers felt their bodily privacy had been violated by the inappropriate gaze of others. While it could be speculated that this activity maybe culturally linked, students

recommended midwives obtain informed consent from parents for other people to stay, prior to labour, so mothers could consider the options and make informed decisions before their pain became too intense.

There were some situations within the study however, such as unusual births, where students legitimised the presence of larger groups of 'voyeurs'; in these instances students justified the need for additional students and staff to be present because of the educative experience provided. Nevertheless, midwives were occasionally described by students as intervening in the process:

'...the senior midwife was obviously aware of how many people were in the room and she dragged myself and the midwife behind the curtain because she said, think of the poor woman. There are six of us in there and she is obviously nervous anyway, so she actually dragged us behind the curtain and closed the curtain and we waited there while he examined her.'

(Year 1: 3 year, Group C student)

The idea of the midwife 'dragging' away the 'extras' produced an image of students and staff resisting the process and wanting to remain. Students appeared to need reminding by midwives of mothers' privacy needs under these circumstances, particularly where their driving force was the need to observe a range of situations in order to learn, even where this compromised mothers' privacy. The following student explained the dilemma concerning students' role as learners during encounters with mothers:

'I have felt really awkward as I have been in situations both in obstetric care and family planning where people have been teaching junior doctors and student midwives and I have absolutely hated it, absolutely hated being sutured and having the midwife saying 'now can you see the apex of the tear, it looks quite big' and I really, really hated it at the time, but there is no other way that I'm going to learn to do it, unless they do that to me and I feel like it's a sort of tread mill that as soon as I am qualified I'm going to be having to show somebody else and I felt at the time really stripped my dignity, I really did feel like people say, a bit of meat.'

(Year 1: 3 year, Group A student)

The dilemma students identified concerned needing to learn about the management of complicated or unusual cases, while using their previous experiences to consider how they felt when in similar situations.

Complicated or unusual cases usually resulted in mothers being moved to high dependency areas following birth, which students singled out as a situation that decreased visual privacy. In relation to

the environment, students described how high dependency rooms often had large glass windows, which faced into workstations or corridors, as two students explained:

'I had to check a woman's pad, she had been up for a couple of hours and I was doing the check and her pad needed changing and it was really almost an after thought that I'd pulled the curtains around..... it was only an after thought because you just don't notice because that window is always there.'

(Year 1: 3 year, Group B students)

'A lot of ladies have said to me that they feel like a goldfish in there.'

(Year 1: 3 year, Group B students)

It appeared to take a conscious effort on the part of students to remember these mothers had insufficient screening and were visually exposed. Students legitimised their actions by suggesting that mothers on view were actually too ill to notice anyway, reflecting previous discussions documented between the student and her midwife (see page 149). Students within focus groups were unanimous in the view that mothers needed to be observed at this crucial time with this need overruling any privacy requirements, as the mothers' safety was paramount. This suggests students were already adopting the professional stance given by midwives in Chapter 5, where they outlined their professional requirement to observe mothers.

Students however were sensitive to the privacy needs of mothers after labour and birth, perceiving them to be vulnerable to observation, particularly when learning new skills and especially those when bodily exposure was necessary:

'Some of them are just like don't mind breastfeeding in front of everyone but some women are very nervous about it. They have never done it before, they don't know if they are doing it right, they don't want people to see their mistakes and they don't want anyone seeing their breasts.'

(Year 1: 3 year Group C student)

It is difficult enough to learn a new skill without performing this with body parts exposed. In these circumstances students perceived mothers were unable to complete their tasks because of an increased sense of vulnerability. Students outlined how they perceived bodily exposure incorporated two concepts, exposure of the novice mother and exposure of the body, with an increase in anxiety where the two were combined. Alternatively, students suggested learning new skills under the gaze of midwives was helpful, however this was contradicted by mothers in

Chapter 4 as they did not want to be exposed to others or have them view their mistakes, considering this to confirm their perceived incompetence as a mother.

Various roles were adopted by students within the study to help ensure mothers' bodily privacy needs were met, to include covering mothers and acting as a privacy monitor. They repeatedly described needing to ensure mothers were covered and not exposed during labour, describing how they '*picked up cues*' from mothers as to whether they wanted to be covered or not, especially as they remained with mothers throughout labour, and therefore considered they gained an understanding of their physical privacy needs:

'I've noticed that you're trying to keep them sort of covered 'just pull that down (the sheet), just a tiny bit' and then you go in two seconds later and they are throwing their blankets all over the floor and their legs are like up there and down there (pointing).'

(Year 1: 18 month student)

Covering mothers actively enabled students to feel engaged in the care process during interactions, with students performing the role of covering because they felt unable to focus on other aspects of care, as the following students explained:

R I think that maybe as students we are more aware of that (covering) at the moment because we are not so focused on all the other stuff.

R Perhaps it's because we don't know it good enough yet so we are still doing a lot of things to the women.

(Year 1, 3 year, Group C students)

Students outlined how they were '*doing*' things to mothers, such as covering, because of their current novice role. However, inconsistency in individual mothers' care requirements resulted in students feeling reprimanded by midwives for leaving mothers exposed, resulting in them being torn between meeting needs of mothers or midwives.

'Its when they are coming towards the end of their delivery they say 'don't worry about that' and they throw the sheet off, you start to wonder if they think that you are a bit silly. Then the midwife who's your mentor or the sister on the ward walks in and this woman is lying there and she looks at you and you think but she wanted to lie like that.'

(Year 2, 3 year student)

The style of covering, particularly during vaginal examinations was debated by both students and midwives. This involved whether mothers' lower abdomen and thighs should be covered or not during vaginal examinations. The following students explained:

'Sometimes, you can like do a vaginal examination with a sheet over them, so its very private but many people just whip the sheets off, whereas you could still have that sheet there, and wait for the client to feel a lot better within themselves.'

(Year 1: 3 year, Group C student)

'When you go for a smear test, they hold that blanket up, it is like now that they have put the blanket there you are now only a person from here up. So I can still look at you and talk to you and look you in the eye, but then I am also going to be doing things below the blanket, but that's now a separate category. It is just the same as the curtain, it's just a bit of cloth but we have made it into this sort of psychological barrier.'

(Year 1: 3 year, Group B student)

Students, within the study, felt using this approach enabled mothers to maintain a modicum of dignity resulting in them considering their bodily privacy as being addressed. This reflected midwives' views where they considered this artificial barrier to enable mothers to disassociate their body from 'them' as a coping strategy during intimate examinations (Chapter 5).

Students described how they adopted the role of privacy 'monitor' in addition to covering mothers during examinations, in response to what they perceived to be poor practice:

'Privacy, I agree with my colleagues is a physical thing, the thought of the woman in a lithotomy position with her pelvic area exposed while she is put up in lithotomy that used to be a thing of mine, you know, give that woman some privacy. Cover her up until she needs to be exposed.'

(Year 2: 3 year student)

Students considered part of the process of monitoring mothers' privacy was the acknowledgment of its uniqueness and therefore, the different types of care and support mothers required. They recommended taking the lead from mothers, as ultimately remaining covered or uncovered, was their choice:

'I think people know that you can't have everything covered up but they're different personalities; I mean everybody wants things in different ways don't they?'

(Year 1: 18 month student)

'You can't say that everybody would want to prance around the room naked. I mean I had a lady the other day who got out of the bath and was quite happy pacing the floor completely naked and she said 'oh don't worry about it' so I knew then that she wasn't bothered, but another lady might be completely different and want to have herself covered and probably want to be in the swimming pool in her swimming costume.'

(Year 1: 18 month student)

By acknowledging the diversity of mothers, students suggested they drew upon their experiences to support mothers in their choices. For example, students questioned midwives' expectations that mothers would remove their own clothes while in hospital:

'There is an issue because we expect these women to take all their clothes off..... Before we have really asked them and some of them might want to labour in their tracksuits. We don't give them that choice.'

(Year 1, 3 year, Group C student)

The lack of choice mothers had over what they wore outlined a dichotomy between students' views that mothers needed to ensure privacy of their bodies, while midwives needed to view their bodies in order to monitor and perform assessments. Enabling mothers to wear their own clothes, students proposed, gave mothers control over access to their body, thus reducing incidences of unwanted exposure. In one example a student described an episode where a mother had been examined and replaced her underwear:

'Sometimes you'll get the shy lady that wants to keep her underwear on and the midwife will just come in and say 'I need to examine you, oh, why did you put your knickers back on, you can't have your baby with your knickers on you know, take them off', and they are made to feel that they are not allowed to wear them.'

(Year 1: 3 year, Group D student)

Students continued to question midwives' reactions to mothers being unable to labour with their underwear on, particularly when they rationalised their purpose as securing sanitary towels, during mobilisation.

Exposure of Body Fluids

In addition to mothers being embarrassed by people viewing their bodies, students considered them to be equally as embarrassed about showing their pads and providing specimens. Students described how they considered mothers to be embarrassed if required to leave a specimen in a public space, where it could be viewed. The following students gave their experiences:

'Wee specimens in clinic they (mothers) come with them wrapped up in tissue and they hand you it and you sort of peel it off to find it. They don't want you to know they have wee'd in it.'

(Year 2: 18 month students)

'I know when I was pregnant we had to come with our samples and you used to either wrap it up or you had this fear of being run over on the way or something and someone

searching through your bag and saying 'what is this!' It was quite a horrible thought. You rushed to the clinic just to get rid of it as soon as possible.'

(Year 2: 18 month students)

Students' perceptions were that mothers disliked carrying specimens in their bags as this was unhygienic, dirty and embarrassing. Their greatest fear was being *'caught out'* by someone who would expose their covert activity, for which they would then become accountable. Students considered mothers not to want to discuss bodily excreta or show it to others, but as they gradually realised this was a necessary component of care, they complied.

Although mothers supplied samples in antenatal clinics, they were also required to produce specimens such as urinating in bedpans or leaving sanitary towels in bathrooms for midwives to examine when admitted into hospital, which resulted in specimens being left in public places, in some instances, for extended periods of time, as the following students explained:

'If you had a period you wouldn't go around and show it to everybody and it's the same sort of thing. Women come in and say they have had a bleed and they come in with their pads wrapped up in tissue and have to leave them out for the midwife to look at them.'

(Year 2: 3 year student)

'The women get quite embarrassed about their pads and things don't they?'

(Year 2: 18 month student)

'Another thing is when they ask you to remove their bedpans from the bathroom and they are not picked up for a couple hours and in a ward where they are sharing a bathroom; it is an invasion of privacy. Particularly if they have clots or whatever in there. It is not very nice is it?'

(Year 2: 18 month student)

To view menses, faeces or urine of other mothers, was perceived by students as an extreme breach of mothers' privacy culminating in embarrassment, thus reflecting the work of Moore (1998), Schneider (1977) and Ross *et al* (1968) where medical students classed excreta as 'dirty'. It could be argued that the perceived embarrassment could be a reflection of the students', who appeared more sensitive to how mothers felt than experienced midwives. Mothers were perceived by students to dislike discussing their body functions, particularly within hearing distance of others, and if asked about bodily functions, in front of others, students suggested they gave incorrect information:

'But asking them have they been to the toilet, have you had your bowels open? You know, they don't always want to say yes, and if they say no, you know that they (midwives) will

probably say, 'oh well it's been so and so days we are going to have to do something about that'. Whereas if you were at home nobody would care really would they?'

(Year 1: 18 month student)

Students regarded mothers as knowing which information regarding their bodies should be disclosed to staff, but felt they were often too embarrassed to divulge it, particularly when it was discussed within a public environment. What they appeared to reflect is cultural shame at disclosing or acknowledging bodily functions as a normal occurrence. Discussions involving body secretions are part of everyday assessments of mothers by midwives during the postnatal period. These assessments generally take place each morning with students concerned that mothers were unable to address basic hygiene needs by bathing or washing before assessments took place. Feeling 'dirty' or unclean made mothers felt particularly uncomfortable about exposing their bodies during examinations as the following student explained:

'On an early shift when you sort of rush off (your feet) and you're doing your postnatal checks most of the women haven't had a chance to have a wash or anything, especially down below and then you're saying to them well can I look, what's your blood loss like, and you can see it on their faces, they're like, don't go there!'

(Year 1: 3 year, Group A student)

There is a contrast here between this study and the work of Lawler (1991) where she suggests that patients who are ill are in a position where nurses can justifiably take control of management of body excreta because patients need help in caring for themselves. As mothers are generally considered to be well during the postnatal period, exposing body excreta to midwives for assessment or in some cases by accident resulted in embarrassment (see Chapter 4) because help in managing body secretions is not usually required when feeling healthy. Embarrassment and the lack of toilet facilities reduced the time students felt mothers had to spend in bathrooms and this, associated with the threat of constant interruptions occurring as mothers sought an empty bathroom, students considered reduced their sense of privacy and solitude in toileting activities. Students gauged their own standards of privacy against the level of privacy they perceived mothers to require in this situation, suggesting that mothers be treated according to this high criterion.

Treating Others as you Want to be Treated Yourself

A common phrase repeated by students in relation to privacy was that of *'treating others as you want to be treated yourself'*. Underpinning this philosophy was their past personal and professional experiences, as the following student explained:

'As a nurse my nursing philosophy was to treat my patients, as I would want my mother, father, son, husband treated and I always survived quite well on that. And I think as a midwife, my philosophy is to treat my ladies as I would want to be treated myself.... if you can look into your heart and think if I was that woman would I want that, then you can't go far wrong.'

(Year 1: 18 month student)

By imagining themselves in mothers' situations, students considered how they would expect to be treated. While midwives in the study described how they transposed their privacy ideals onto mothers, students suggested midwives had lost this ability and had become immune to mothers' privacy requirements because of the repetitive nature of their work which desensitised them to the process.

R1 I think it's because they (midwives) just get so used to it, don't they? It's everyday run of the mill and I know it sounds awful but it becomes just a job doesn't it?

R2 Yeh, you become desensitised.

(Year 2: 3 year students)

Desensitisation, students suggested, was the outcome of midwives being in continuous and prolonged contact with mothers, where day-to-day physical contact became routine or mundane.

One student stated how this applied to her and her peers:

'We are getting to that point now where we are seeing women with their bits and bobs everywhere, whereas before when we first started you think oh cover up, you know, its like you get used to it and now ones much the same as another.'

(Year 1: 3 year, Group B student)

Desensitisation enabled students to overcome their initial embarrassment of viewing parts of a mother's body, which were not usually exposed, describing this as becoming 'accustomed' to the situation. However, students' perceptions were that mothers were equally as embarrassed as they were during encounters. Students appeared to be in transition between mothers and midwives, empathising with midwives as to why this occurred, while being realists in that they considered this would eventually occur in their own practice.

Students acknowledged that mothers were often ignored during encounters with obstetricians, particularly where doctors talked across mothers, as if they were not present. This reflected discussions in both Chapters 4 and 5 where both mothers and midwives described this as occurring, but only in relation to doctors:

'Well sometimes the consultants talk over the ladies they don't even actually speak to them and they are saying after they have left the room 'what did he say' and 'am I all right; is everything all right'.

(Year 1, 3 year, Group D)

'When I was with a lady last week, there were two doctors on either side of the bed and they completely talked across her and left and she had no idea in the gobbledy-gook that they were speaking what it actually meant and she felt very threatened and very isolated in some respect.'

(Year 1, 3 year, Group D)

Students felt being 'talked over' resulted in disempowerment and objectification of mothers lessening their overall birthing experience. They perceived the role of the midwife in these situations was to inform doctors about poor practice:

'We need to say to the doctors look you know we're not just dealing with a piece of meat here we are dealing with a woman who's going through what should be a very special time and if we carry on like this its not going to be that way.'

(Year 1, 3 year, Group A student)

Students argued that through this process midwives and doctors disassociated themselves from individuals:

'Maybe that is why surgeons are so rude to people sometimes because they dehumanise them (the patient), if they think of you as that girl that I was talking to then they might find it hard to cut into you. Maybe it's their way of dealing with things.'

(Year 2: 3 year student)

Disassociating or dehumanising mothers was perceived by students to be a coping strategy for professionals to enable them to perform invasive and intimate procedures or actions without embarrassment. One way that midwives appeared to manage this situation was explained by students as separating the 'mother' from the 'body', thus enabling midwives to initiate physical contact without feeling they had affected mothers' perceptions of intruding on bodily privacy:

"Like the pregnant body is a completely separate issue from the normal body. Because some how they separate the pregnancy bit from the person bit and it is all right to touch."

(Year 1: 3 year, Group B student)

To summarise, students are in a unique position during their training of being able to watch and learn during mother/midwife interactions. Students' explained how mothers entered the system shy and naïve but during the care process became compliant. Following contact with midwives and doctors it was students' views that mothers' privacy declined through being, viewed, touched or treated with disrespect. In relation to midwives, students felt they often perpetuated poor practice

resulting in them having to provide privacy care. Students expressed empathy with mothers using their own previous experiences as a foundation on which to base their care. They considered their practice to be skills based, maintaining privacy by 'doing' things to mothers. By rationalising their care provision students worked on the principle that by treating others as they wanted to be treated, the standard of care provided would always be of a high quality. While this section has addressed physical aspects of care the next section addresses the impact the environment has on mothers' ability to meet their privacy needs.

The Environment of Care

This section presents students' perceptions of maternity environments and the role they perceive it played in influencing mothers' privacy. As shown in Chapter 4, mothers found the acquisition of personal space within wards difficult because of overcrowding; whereas midwives described the environment as providing tension between meeting mothers' privacy needs, while addressing the maternity setting as a working environment. Alternatively, students' views on the care environment included discussions on mothers' need for personal space, access to bathrooms and toileting facilities, entry to accommodation, and layout of wards, observation of mothers by others and overhearing conversations. The first section addresses students' views on the lack of personal space for mothers.

'Everyman and his dog came in': the notion of personal space

The hospital environment offered challenges to the attainment of personal space as has been shown in Chapters 4 and 5. Students described how mothers were unable to gain privacy within hospitals, even within single rooms, sensing they were resigned to the fact they would not receive privacy from intrusions while hospitalised, because they were visitors in the environment. Moreover, students believed midwives to consider themselves to have unquestioned right of entry to mothers' space, in any situation or environment. This perceived right of entry resulted in a culture of open access to mothers, irrespective of conditions, as the two following students explained:

'I have been in a situation where the cleaner has walked in, to change the water jugs right in the middle of an examination and I just wanted to cringe and I felt really terrible. Her privacy (the mothers) and everything had just gone out of the window.'

(Year 3: 3 year, Group A student)

'I was checking with somebody if they needed stitches and a healthcare assistant came bowling in the door, stood at the end of the bed and was just looking and she said, so and so just come in, what room shall I put them in and I just felt it was just absolutely disgusting for that client.'

(Year 1: 3 year, Group C student)

There was consensus amongst students that mothers accepted these intrusions because of their lack of ownership over their surroundings, naming doctors, senior midwives, relatives, support staff and students as people who entered rooms without seeking permission. These invasions, students suggested, could be reduced by placing mothers' names on doors. The philosophy of not disclosing names on doors appeared to be based on the potential for breaches of privacy from other visitors gaining information on residents. However, the impact of a lack of labelling on doors resulted in inappropriate intrusions from a range of visitors and staff:

'I have actually had a man walk into our room thinking it was the room that his wife was in, he just came straight in, ... there was no knocking or anything.'

(Year 2: 3 year student)

'They go off to the toilet and come back and they have got a bit disorientated then again they haven't knocked either, they have just presumed that it is their wife's room and they have walked straight in. It is a genuine mistake.'

(Year 2: 3 year student)

'I do remember in mother mode not student midwife mode, feeling like that, that every time the door went you think 'who's that coming in?'

(Year 3: 3 year students)

'Because we don't have names on the doors, because of privacy it does cause confusion because only a few weeks ago a consultant went charging into one of the rooms and said to this lady 'oh right you are going to have a caesarean section .. it was completely the wrong room. Now obviously a name on the door would have helped but then you have problems with privacy.'

(Year 2: 3 year students)

'I have walked in and the lady was having a VE done and I was 'oh, I am so sorry.I didn't know where this buzzer was coming from and I was trying to find it. I felt so embarrassed.'

(Year 1: 3 year, Group B student)

In an attempt to reduce intrusions students described how midwives placed notices on ward doors, to heighten awareness of the activity being undertaken within.

'They do put notices up on all side wards put notices on doors, mothers feeding or mothers sleeping or stuff like that, on the side rooms generally'.

(Year 1: 3 year, Group A student)

However, even where notices were displayed on doors this did not ensure compliance by staff.

Students described a distinct lack of social etiquette around right of access to mothers' rooms, as did midwives (Chapter 5); reporting that practitioners would knock on doors prior to entry, but enter before consent was obtained. One student cited the following incident:

'I have seen doctors come in and they definitely don't knock or anything. They just come in and everybody clears out of their way.'

(Year 1: 3 year, Group B student)

Although students acknowledged midwives' lack of knocking etiquette the examples given were of problems associated with doctors. They suggested doctors did not appear to need permission to access mothers, and midwives' did not challenge this, therefore legitimising their actions.

Admittance to mothers' rooms appeared to include a professional etiquette. Students described how they sought permission to enter mothers' rooms by gaining consent from the midwife leading the case, rather than mothers. The rationale for this being associated with the midwife's role as advocate:

'The midwife who is advocate for the mother should be able to answer to some extent for the woman, so that she is not being interrupted all the time. She might be in the middle of a contraction or anything. Surely it is the midwife who will direct whether you ask the mother or whether you ask her. So you would go to the midwife and ask her.'

(Year 1, 3 year, Group C)

Students perceived that mothers wanted to get on with 'their job' of having a baby and with pain management, and therefore deemed it more appropriate to place requests for admission through the midwife so that mothers were not disturbed.

One of the largest reasons associated with intrusions into rooms was '*looking for the keys*'. Within the focus groups students gave numerous examples of how midwives, under the auspice of searching for keys, entered rooms without knocking.

'They don't wait for an answer they just walk in and say have you got the keys and by the time they have finished that half a sentence they are virtually through the curtain as well and you just think, look hold on a second, you know, knock on the door.'

(Year 3: 3 year, Group C student)

Students sensed midwives used looking for keys as an excuse to enter rooms to find out what was happening within, reflecting the views of midwives in Chapter 5. Students observed that midwives' right to entry to find the keys took priority over the needs of mothers, with students suggesting this was an inappropriate and time consuming activity, which increased intrusions.

In order to combat unnecessary intrusions, students described how most delivery rooms had internal curtains behind the doors in an attempt to shield mothers from view. I asked students if they were used:

'Yeh, there's a door and then double curtains so it's really nice, that's a really good thing for privacy. ... They can stand completely behind the curtain, they have a conversation with you through the curtains sometimes as well and it's a bit uncomfortable.'

(Year 1: 18 month student)

In order to monitor right of entry to rooms students recommended that midwives took control over admission to mothers' personal space. Where midwives acted as privacy advocate, in these circumstances, then intrusions were noticeably reduced. This was similar to students acting as privacy monitor.

The introduction of small slatted windows on doors, which could be opened so viewing could occur, without staff entering rooms, was introduced as an alternative approach to reducing intrusions. One student described their use:

'Sometimes they look through the window, you know the doors have those little blinds and I think the women are aware that someone is opening the blinds and peeking in. They feel as if they are invading their privacy needs by doing that.'

(Year 2: 3 year student)

Where slats were present mothers and staff appeared to have even less control over who viewed them, unless they could be locked from inside the room. 'Peeking' through windows, students perceived, resulted in mothers feeling as though their privacy had been breached, as they were uncertain as to who was watching them. Students considered midwives to perceive themselves as having legitimate right to 'peek' at mothers and therefore, did not regard this as an invasive act on their part.

Students recognised the need for mothers and partners to be together in the postnatal period at what they perceived to be a very personal time. The requirement for personal space on admission

to postnatal wards was perceived by students as central to the attainment of privacy. They connected this to mothers wanting their own time and space in which to do their *'own thing'*.

'It is very important especially after your delivery to have time to yourself and your loved one and get to know your baby.'

(Year 1, 3 Year, Group D)

One method attempted by mothers to secure personal space was to pull curtains around their beds. However, students were aware of midwives' needs to observe mothers without hindrance.

The following group of students explained:

R1 Some of the midwives don't like the curtains around all the time because somebody could collapse behind there and nobody would know. They could be lying there then for an hour without anybody knowing.

R2 you do go in and it's the deepest, darkest hole of Calcutta, all the lights are off, the curtains are pulled and really, ok they like their own space but there is no need for it. They think I just want to shut myself away.

R3 Its society isn't it? Society is changing we used to be a society where we would speak to our neighbours on the doorstep. We are not use to having to communicate with people that we don't know. people are like 'oh I don't want to talk to them. I don't know them. We haven't been formally introduced.'

(Year 1: 3 year Group A students)

Students perceived ward environments to reflect cultural norms, where mothers do not want to mix with other mothers, even when in small hospital wards. However, it was students' impressions that mothers were more able to learn from each others' experiences when interactions were enhanced. Of particular interest in the extract above, is participant R2, who states that *'there is no need for it'*, her perception being that mothers did not require solitude or space, with promotion of social interaction being paramount, which also reflected the views of midwives described in Chapter 5. In reality students were aware of the uniqueness of hospital environments, with some students considering wards as places where mothers could interact and share a sense of camaraderie, while others perceived them as places of confinement which perpetuated invasions of privacy. The following students described their views:

'I think especially with postnatal wards it is such an abnormal situation. It is like a dormitory at boarding school type of thing, shoved in a room with 5 other women that you have never met before and are not going to meet afterwards. All walking around in their nighties I think its just a really weird context.'

(Year 1, 3 Year, Group B)

'You're expected to go and sit and eat dinner round a table, with people that you don't know. That was really a crazy thing. You know when eating in front of other people, going off to the toilet in front of other people. It's all so open, and personal.'

(Year 1, 3 Year, Group B)

While another student recited her own more positive event:

'I loved it because everybody spoke to everybody and we were able to sit and watch the tele and it is totally different now at night you close the curtains. We had a great time then. Everybody got on.'

(Year 1, 3 Year, Group D)

Students within the study were largely unanimous in their view that mothers accessing ward environments preferred single occupancy rooms, because of a higher standard of privacy attainment. The following students discussed why:

- 'R They get better types of care then if they are in the sideward?*
- R Yeh, yeh. They have their own little private bathroom don't they?*
- R They have ensuite*
- F If you had a choice where would you go?*
- ALL Side ward (all) laughter.'*

(Year 1, 3 Year, Group A)

As side rooms were generally unavailable, students described how mothers pulled curtains around their bed to secure personal space. However, students felt this gave mothers a sense of being within their own environment and a false sense of security, as the following students outlined:

- 'R1 When you are enclosed in that environment you kind of think you are shut off from the rest of what is going on.*
- R2 You're in another world.*
- R1 So you think that you are in your own little environment behind the curtains and nobody knows that you are in there, or what is going on inside. You don't realise.*
- R2 You get a false sense of security.*
- R1 It's because when the curtains are drawn back you suddenly realise, but it is too late by then everybody is looking at you.'*

(Year 1, 3 Year, Group C)

'Even with the curtain closed around you can still hear what the woman next to you is saying. When I was up on the ward ...it was a visiting time, we had this lady and she was to be induced and just the curtains were pulled, visitors either side could hear everything that was going on and I was embarrassed when the curtains were pulled back, everyone knew what had just happened and I was really embarrassed for her.'

(Year 1, 3 Year, Group C)

'It is the ward environment really; there is little privacy there. You can determine whether you have physical privacy but you know, people just hear everythingit is really not a very private environment.'

(Year 1, 3 Year, Group D)

Students considered mothers should have choice about whether their bed curtains were drawn or not, as midwives spent time pulling curtains back, so they could see all mothers. While curtains went some way towards ensuring physical privacy, students considered them unsatisfactory in preventing disclosure privacy, particularly during examinations. Students recommended the use of a treatment room where mothers could go for treatment, such as inductions and where they could stay following procedures thus enhancing both physical and communication privacy.

Advising mothers to have their baby at home was the only way that students supposed mothers could achieve their privacy. At least two students within the study had been present at homebirths, outlining how mothers remained in control of their surroundings and subsequently their privacy. One student stated *'they are on their own territory and they are more in charge'*. Students described mothers as more assertive and controlling when in familiar surroundings, with the midwife having to ask permission before each event, because of her role as guest within the mother's home, as the following students described:

'R It is hard even just down to washing your hands. You have got to ask permission to wash your hands and it is something that you do automatically in hospital.'

R It is as though you are a guest in their home and there are a different set of rules.'

(Year 2, 18 month student)

The discussion reflects the work of Magnusson and Lutzen (1999) where the home was associated with personal integrity and where patients were partners in the care process. The student above was of the opinion that midwives asked questions in different ways in mothers' homes as compared to hospitals, because of the midwives' visitor status within the home. This highlighted a distinct difference between disclosing personal information in the privacy of the home as compared to disclosure within public environments of wards, where disclosure of information commonly occurred behind closed curtains.

Disclosure of Information

Disclosure of information occurred in a range of settings within the study and through a variety of means, such as, gossiping, discussion of cases and overhearing conversations. Students'

considered mothers should control of the decision regarding what personal information they would allow staff to disclose, and only once permission has been obtained. The importance of ascertaining if information could be divulged to a relative was highlighted by the following extract:

'R1 You know we had a lady on delivery suite with a post coital bleed and she brought her mother in and I think you have to be quite careful really.'

R2 Yeh there are things you would tell your mother and things you don't.

R1 Yeh. So I do think we shouldn't assume that because they have brought someone with them that it's absolutely fine to discuss everything in front of them.'

(Year 2, 18 month student)

Inappropriate divulgence of information was perceived by students as gossiping and part of the unofficial daily activities of midwives. Students gave examples of staff chatting and gossiping about mothers, which they associated with rudeness, lack of respect, and problems with attitude. Where gossiping took place within the public arena it was perceived by students to influence the privacy of mothers, by breaching confidentiality and respect. Students, however, were realists, considering gossiping as inevitable in any work environment, based on the notion that we are *'all human'*. In one extract a student described how a father attended labour ward with his mistress and the information travelled around the maternity unit, because of the *'juiciness of the story'*, even before the mother had delivered her baby. Midwives were perceived by students as generally *'chatty'* and students related this to their need to tell a good story:

'I think that's got a lot to do with the fact that 99% of them are women, women are chatty, gossipy people. ... it's like going to a girls school most of the time, back biting and gossiping and the like.'

(Year 1, 3 Year, Group B)

'Midwives chat don't they, when you are sitting there you hear about it and then somebody says to you, did you hear about that?'

(Year 1, 3 Year, Group B)

Students perceived themselves to become involved in gossiping by default, as they were in the wrong place at the wrong time and ended up overhearing. When questioned by someone else interested in the subject matter, students felt obliged to disclose the information. Although midwives were heard to talk about mothers, students stated they never discussed mothers with another mother, suggesting a social order to gossiping. However students did highlight areas of poor practice of which they were critical, to include, where *'chatting'* or gossiping bordered on the rude or insulting:

'I got handed over a lady the other day who had smelly feet and it made the room stink. They said oh, she could have washed her feet. It had nothing to do with her care at all. ... it's gossiping isn't it?'

(Year 2, 18 month student)

In a second extract within the same focus group another student described an incident where a mother refused a vaginal examination. The student overheard a group of midwives discussing the refusal and reported one as stating *'how did she get bloody pregnant in the first place'*. Students linked gossiping with a lack of respect for the person and their privacy, suggesting that personal information should never be used disrespectfully.

While gossiping was perceived to take place between midwives, discussions on cases were reported as taking place between students as a process of constructive learning in the classroom:

'Sometimes it is nice to know how the others would react in that situation to see if your reactions were the same.'

(Year 2, 18 month student)

This type of more formal discussion, students felt, enabled them to compare practice and confirm the appropriateness of their actions in a constructive and supportive environment. This was in direct comparison with discussions between staff in clinical areas, which were perceived as informal and completed in a range of settings, such as, coffee rooms or nurse's stations:

'R1 They're in a room on the wards and delivery suite, it (informal discussions) usually happens when they have coffee'

R2 Yeh, in the staff room'

F Could people overhear these conversations?'

R3 They could on delivery suite.'

R1 And on the wards actually because sometimes you're sitting in that room doing the hand over in that room and the doors open and people could be listening.'

(Year 1, 3 Year, Group B)

These informal conversations had the potential to result in disclosure of information to other mothers. Students implied that breaches of privacy frequently occurred. However, it was usually the dramatic or interesting cases that were discussed in detail. During one focus group students discussed a very difficult case in which three of the students had been involved. These students were under the misconception that they were the only people who were informed regarding the case, however once students started to discuss the case, it became evident that the rest of the group were also aware of the details. Students within the group had heard about the case from

various sources, including other mothers, friends, peers and midwives. The students involved were distressed at the extent to which the information had spread, and how quickly and widely it had been disclosed. The level of public and professional disclosure in this case highlighted how even though professionals work within a regulatory framework for confidentiality (DH 2003), disclosure still occurs.

One conduit of information disclosure was the open environment of wards. As with any open environment, students considered conversations were overheard or listened to by others, making privacy difficult to maintain:

'It is the ward environment really; there is little privacy there. You can determine whether you have physical privacy but you know, people just hear everything.'

(Year 1, 3 Year, Group C)

Students' indicated that they considered mothers did not intend to overhear conversations.

However, there was difficulty in keeping conversations, in open areas, only to those that needed to be listening. Where mothers were sited students considered impacted on their ability to influence their levels of privacy attainment, with breaches occurring more in open environments, than in closed environments such as single rooms, as the following student explains:

'We had a lady who was expecting twins and one of the twins was a suspected IUGR (intrauterine growth retardation) and did actually die. The lady was brought back upstairs to the ward because she still had the other twin and I remember hearing a conversation going on with the midwife saying that she should be put into a side room and the doctor said 'oh, no she will be fine'. They put her in a bed in the CTG bay and I was sitting in the bay with a lady and could hear everything that was going on. She was obviously quite distraught that she had lost one of the twins, not only for her but for the rest of the ladies on the ward who were all expecting babies.... they could hear everything that was going on. But it was the registrar involved that was completely oblivious to the fact that he had just stuck her in a ward with 7 more antenatal ladies.'

(Year 1, 3 Year, Group C)

In this data extract the doctor appeared to dominate the mother's admission to the ward rather than the midwife acting as her advocate by ensuring allocation to a single room. This was a distressing time for the mother and other mothers in the ward as they became unintentional eavesdroppers to her grief.

Where conversations could be overheard within the environment, students felt it placed restrictions on the content and type of conversations undertaken between midwife and mothers:

'I don't think they are always so open because they know that people can hear. Maybe we should have a nice little room where they (mothers) can sit and relax and ask questions.'

(Year 1, 3 Year, Group D)

Students identified that in some cases mothers did not disclose private information as partners were present. One student described her experience:

'If their partners are sort of more powerful they'll probably feel intimidated by that so they (midwife) probably wouldn't get as much information from the woman with the man that sort of stands there, if you say would you go out, then the women talk to you and they tell you amazing things.'

(Year 2, 18 month student)

However, students continued to state that in some instances asking partners to leave could also impact on mothers:

'If your giving them the choice that you can leave if you want to, or if you would like your husband to leave then say so, then you are putting her in an awkward position because she might actually want them to leave but feels as if she can't say.'

(Year 3, 3 year student)

Students discussed how midwives could tell if a mother felt intimidated by her partner (cited as *'midwives intuition'*) and developed tactics to remove them from the room, such as sending the partner for *'a cup of coffee'* as the following student explained:

'I am more aware of Asian men these days, 'I am going to examine your wife now would you like to stay in the room, or would you like to go and get a cup of tea' that type of thing, because invariably the men don't want to be in the room when you're doing that. Perhaps it is more a cultural thing.'

(Year 2, 18 month student)

Students thought partners of Asian origin were more likely to want to leave the room during examinations than other partners, although there is no direct data within this study to support this notion. However, in some instances students described how it was mothers who initiated the removal of partners from rooms by giving them consent to leave, through comments such as, *'why don't you go and put your car parking ticket on?'* At this point mothers would speak in confidence to midwives and intimate examinations could be performed without partners present. Students' views were that where mothers instigated removal of partners it was usually the mother who did not want them present during examinations.

While disclosure of information occurred within a range of settings other forms of disclosure occurred through records kept by midwives and it is these sources which are discussed in the following section.

Documentary Privacy

Various methods of recording information have the potential to facilitate disclosure of information and breach mothers' privacy. Students considered these to include hand-held records, notice-boards and the use of video cameras during birth. Students believed confidentiality of personal information to be of high priority to mothers' on admission to hospital. They perceived confidentiality related to any information which mothers did not want disclosed to a third party, ranging from social to physical problems.

Hand-held notes were issued to mothers at their first meeting with the midwife and in some instances may have been completed by mothers prior to the meeting, giving them greater control over information divulged. During one focus group students discussed the relevance of information documented in these records:

'Does she (mother) want the fact that she has had two abortions before, written in her hand held notes? Or is that something that can be put into hospital and GP notes so that other people know that you know that her husband or her mother might not actually know.'

(Year 1, 3 Year, Group A)

'We had a girl the other day who had syphilis about 7 years ago and she had the all clear from her own GUM clinic and didn't want her partner to know ... but of course it is on her notes. my issue was, was anyone at risk if it wasn't written anywhere?'

(Year 1, 18 month student)

Students suggested this type of information should be included in complementary notes held by the hospital or GP, access to which could be restricted. Once mothers had disclosed information, students felt midwives were obliged to include it in records, even though they considered it irrelevant. They were concerned about the impact this may have on mothers' relationships with their partners, if the information was ever disclosed, particularly as notes were kept with mothers during labour. Students considered labour as a point where notes were more vulnerable to access as *'anyone can pick them up and read them'*.

One method of dealing with sensitive information was the introduction of a duplicate or additional set of records. One student described her experience:

'In an ideal situation ... the woman can be given the choice not to have it included (information) in her hand held notes, but do we always remember to give that choice? ... We just ask the question and then the woman just assumes that if she answers the question that it just goes on those notes. But then conversely, you could say that the woman is in charge of her own notes, if she doesn't want other people to see it then she doesn't have to let anyone else see it.'

(Year 1, 3 Year, Group A)

Students suggested mothers should be given the choice as to whether details are included in records and it should not be assumed that if the mother discloses information she is happy for it to be documented. However, they also added an important point, by stressing that ultimately mothers are in charge of their notes and should police who has access to them. However, it could be argued that mothers disclose information they deem to be relevant and then have to contend with it's exposure in their records.

An alternate source of documentary privacy which had the potential for disclosure of personal details, were ward notice-boards. These were frequently cited by students as sources of disclosure because of their role in documenting ward occupants and types of problems they were experiencing. The boards contained detailed information on mothers, their ages, problems with pregnancy and stage of labour. The following student explained their use:

'On labour ward they have a notice board and they put up that a woman was going to have a baby that was not compatible for life, but decided to carry on with the pregnancy and all of her details were just put up on the notice board with her name and everything. ... a lot of people use that office and just walk in and out that have nothing to do, or will never care for that woman, and I have a bit of a problem with that really.'

(Year 2, 18 month student)

Students did not consider this type of information to be safe from being viewed in this environment, particularly by unnecessary staff or visitors. During observations it was noted that the boards used were placed in different areas, for example, on delivery suite, it was placed within the main office behind the door, thus not available to general view. On wards, boards were at nurses' stations but here information contained was either abbreviated or scarce. However, this does not reflect other sites where students may have been working.

An alternative source of documentary evidence resulted from the increasing trend of recording of the birth, using video cameras, which students discussed as having potential to breach mothers' privacy. They considered parents to be ill-informed regarding this type of recording and its explicit content, as the following extract identifies:

'I've been with a midwife that's been asked that at the beginning of the delivery and she said that she would prefer it if they didn't (video the birth), she really didn't feel comfortable, snap shot fine, and as long as she was not the focus of the picture, because she said you never know, videos might just fall into the wrong hands and your wife might not want whoever gets hold of it, to be looking at that. She put it in that way and I don't think they had considered that. It was just their way of recording it for themselves and they didn't realise that once it was recorded they hadn't really got that much control over who sees it later. And they did then say yeh perhaps you're right, we'll just take pictures.'

(Year 1, 3 Year, Group A)

However, in the following data extract the student describes how the midwife was unable to prevent the father from taping the birth:

'The hospital where I was working had a policy of no video cameras, because of legal reasons... and it got to the point where the head was coming out, there was no way we could say sorry, we are not helping now, and he got his video camera out and was asked to put it away a couple of times and the woman was asking him to put it away.. and he wouldn't..... at the time I was very focused on what I was doing but I felt really mad, and I thought hang on a minute, you were videoing me and your wife who didn't want you to, against all of our wishes and that was a real privacy thing. It makes you angry.'

I continued by asking the student what she thought the mother's views were after the event:

'He was saying, 'I'm going to send this to her mother'. And I'm thinking her mother won't want to see this. And she was saying, just take a picture, just take a picture and it was horrible. And afterwards I felt really angry because he had done that and I did want him to stop, maybe that's how the women feel?'

(Year 1, 18 month student)

The other students in the focus group continued by expressing their views on problems with available technology:

'R1 It crops up quite a bit both for the privacy of the woman and for the other people involved in it. ... who do you show these tapes to afterwards? What happens if your house is burgled and the tape is stolen?'

R2 He was saying no one else will see it.

R1 Well he wants to send it to the mum for a start, so it could get lost in the post.

R2 She was in Mexico. They will probably think they have a dodgy video.

R3 You could end up with your boobs on the Internet (laughter).'

(Year 1, 18 month students)

'It is not the sort of thing that you could bring out at your buffet dinner and say have you seen the video of my wife in labour?'

(Year 1, 18 month student)

Students were concerned that mothers had no control over who saw the recordings once made and recommended that midwives act as advocate in determining whether mothers wished to participate in the recording prior to labour. It is interesting to note that neither mothers nor midwives discussed this form of technology within their interviews or focus groups.

The key themes identified by students within this section relate to their perceptions of the environment as one where professional needs for access were placed before that of mothers'. Students described how they had a procedure for accessing mothers through midwives, whereas other people appeared to be able to enter mothers' accommodation without feeling the need for consent. Students provided practical solutions to difficulties they identified; for example, placing signs on doors and making sure bed curtains were pulled if mothers wanted in order to secure visual privacy. Students also highlighted problems with disclosure privacy where they perceived midwives to gossip about cases, which they considered was disrespectful. However, when students discussed cases this was considered part of their programme of learning and only held in settings where confidentiality could be assured. In comparison, students also described how breaches in privacy occurred through use of notice-boards, client-held records and videos. While some of these were discussed by both mothers and midwives, neither considered the use of video recordings in their conversations. Alongside these issues students found themselves working within a professional setting, which included its own compounding issues for mothers' privacy, as will be shown in the next part of this chapter.

Improving Privacy: The Role of the Student

Within the study students outlined a number of issues which they perceived influenced mothers' privacy, which were linked together under the theme of improving practice. This included how students believed they helped facilitate improvements in privacy care and the general realities relating to their 'job'. Aspects outlined by students as warranting change so as to improve privacy for mothers included making friends with mothers, showing respect, particularly for their choices, asking permission, teaching privacy skills to staff, empowering mothers to know how to achieve privacy in clinical areas, and addressing attitudes and assumptions of staff. Students also identified a number of issues linked to their role as students to include, being with mothers, being a student,

intruding on partners' personal experiences, acting as advocate and the influence of their previous nursing experience, where applicable.

Improving Privacy through Friendship and Social Etiquette

Students within the study were vocal in offering guidance on improving mothers' privacy experiences through developing friendships and improving social etiquette, by befriending mothers, ensuring respect and dispelling assumptions and attitudes that impact on the care they received. Students recommended befriending mothers to enhance their ability to act as advocate and determine mothers' privacy needs:

'You get great satisfaction on delivery suite when you are working and caring for a client and you have actually made friends and cared for them. You want to give them one hundred percent.'

(Year 3, 3 Year student)

'You have something slightly different between somebody that you know and somebody you have got used to, the difference is the long term relationship that you have built up over a period of their pregnancy, rather than having to build up a relationship in ten minutes. You may have taken over the care from somebody who is quite far on in labour and you have to build up that relationship very quickly and it is a different relationship.'

(Year 3, 3 Year student)

Longer term relationships enabled students to act sensitively towards mothers because of prior experience of their privacy needs. One student identified how being allocated to a mother who was near to delivery meant she had no time to discuss her care needs with her:

'I had a situation where I did feel that I had gone against the woman's wishes but not knowingly a woman had just been transferred to the delivery suite literally as I was coming in the door, ... and it was a case of 'do you want to take over this delivery' so I said yes..... Just as I was writing the care plan to transfer her upstairs (after the birth) I noticed that it said on the care plan, no student midwives and I felt terrible.. and I didn't know what to say. ... After that every time I was introduced, I introduced my name and said I am a student.'

(Year 3, 3 Year student)

The student described how lack of prior knowledge of the mother resulted in her feeling guilty for caring for her and responsible for going against her wishes. The result was a learning experience with the student planning to make a conscientious effort to consider the privacy needs of mothers in the future by introducing herself. Introductions are important to privacy as a means of creating a relaxed and friendly encounter between two individuals, who 'know' each other, even if for a short

period of time. Students outlined how they were often *'thrown in with a mother'* without appropriate explanations being given to mothers as to their role, which resulted in them feeling as though they were a voyeur intruding on a personal event.

'R1 All they want us to be in for is the delivery, as soon as we come in we are getting our gloves and it just gives the view that all we are interested in is catching that baby and that's it and that's not true. As a woman myself I don't think I would have appreciated it with someone saying 'oh by the way this is so and so and she is just going to catch your baby. As soon as it's done then you are gone. It's rude really.'

R2 It is almost like having a party at home isn't it when someone just arrives for food (laughter).'

(Year 1, 3 Year Group D)

Students describe an impersonal approach to care that did not facilitate development of a relationship with mothers and where delivering a baby was seen as a task to be completed on the road to qualification as a midwife. This mechanistic approach does not facilitate an understanding of the needs of that mother and is expressed by students as an intrusion of privacy.

Placing themselves in mothers' situations and considering how they felt under similar circumstances, students considered fundamental to their practice. This process concerned *'respecting wishes'* and considering the privacy needs of mothers through students' own experiences. A key component to this approach was facilitating choice for mothers. Students suggested that if mothers chose their path of care and felt in control of the situation, then they had a sense of control over their privacy. Not only was increasing mothers' awareness of choices important, students considered midwives needed to revisit their skills in privacy etiquette. One student offered her view on a solution.

'I just think that sometimes it's our bedside manner; people need to be taught a better bedside manner. There are ways of asking things in a quiet manner without drawing attention to it and without embarrassing the woman, because you know when you say to them, have they had their bowels open, I always tend to lower my voice anyway.'

(Year 2, 3 Year student)

Good bedside manner such as lowering one's voice and acting respectfully towards mothers students considered needed to be maintained post-qualification, supported by refresher courses. One group of students even suggested introducing the idea of privacy needs into parent education classes to heighten awareness in parents:

'Perhaps it needs to be reinforced in parentcraft because I haven't seen it covered in length, that is privacy in hospital. You can actually ask for your privacy if you want to. That's why people don't know that they can say no, because they are not told that they can. They just assume that they can't.'

(Year 1, 3 Year, Group D)

Students considered introducing privacy early in antenatal classes would increase mothers' awareness of privacy as an issue and prepare them for any impending problems on admission to hospital.

Privacy was perceived by students as unique and individually specific and therefore general assumptions could not be made regarding privacy needs of mothers; because of this students identified their need to adapt their practice accordingly as the following student explained:

'It is hard to label it because everybody keeps different things private. They view something that is private to them, might not be private to someone else. I think it is important to recognise that just because you might think it's private or not private does not mean another person will think the same thing. ... it is just different for everybody and I think that you have a right for whatever reason to keep it private.'

(Year 1, 3 Year Group D)

In one data extract a student described how mothers differed reflecting the views given by midwives in Chapter 5, for example, some would enter the room and take off their clothes without prompting, while others appeared more inhibited, with privacy needs influenced by individual wishes and cultures.

The attitudes of midwives were identified by students as impacting on the privacy care given to mothers, as one student explained:

'I think that the views of the midwife on privacy impact as well, as you may feel that you don't want to ask a question because to you it is private, that lady might not mind, but you don't want to ask it because to you that's embarrassing, you wouldn't want to be asked the same thing, so you are inhibited in that respect because of your own personal views on privacy. ... Because we are all at the end of the day people, we are going to be midwives at the end of this but you still have your own views on privacy, the problem is as the time goes by you become less embarrassed about talking about things but you are still people. People have their own things about stuff don't they?'

(Year 1, 3 Year, Group D)

The idea of the student or midwife being embarrassed influenced the questions they asked mothers. Questioning was considered by students to be influenced by personal attitudes described as *'the way you talk to people, the way you behave around people'* and was linked by students to respect for the person.

Having a poor attitude was associated with the respect midwives portrayed towards mothers and was linked by students to social etiquette skills such as, asking permission to undertake invasive procedures, as one student explained:

'I think the main thing is explaining why you are going to do something and making sure that you get permission whether it be verbal or whatever, but if you explain the reason for something then somebody doesn't feel that their privacy has been invaded and that relationship signs the fact that they don't feel that they have had their privacy invaded.'

(Year 1, 18 month student)

Where permission was sought from mothers, students' suggested they remained in control of events and felt able to participate. Students also advised that by increasing information given to mothers it in turn increased their confidence, enhancing their ability to 'say no' and take control of their situation. While building up relationships and developing a good 'bedside' etiquette was deemed as important by students, occasionally students described how their job impacted upon the privacy mothers required.

Being a student

Students identified elements of their role which appeared to influence mothers' privacy. As they considered midwives too busy to address mothers' privacy needs students readily adopted this role, regarding their supernumerary, non-registered status, enabled them to spend more time with mothers. One student described her experience:

'As a student you have got more time, you aren't under the pressure where the midwives do have a lot more pressure, they have a larger case load, they're accountable, so we tend to have that little bit more extra time to be able to spend with the woman and actually give that sensitivity and care and privacy.'

(Year 1, 3 Year, Group A)

'But sometimes as a student you are the one that is in the room with her a lot. The midwife sort of goes and comes back, but they tend to leave me in there and so you're the one that is really talking to her and finding out what she wants.'

(Year 3, 3 year students)

Students considered themselves to be the person spending most time with mothers, especially during labour, and so felt they had a greater understanding of the privacy needs of mothers than midwives. Students believed that if the number of practising midwives was increased this would enable mothers to have the privacy care they deserved. As students also learnt about privacy through working with their mentor midwife, increasing midwifery staffing levels would ensure they could have adequate support during their training.

Although students considered staying with mothers during labour was important for the identification of privacy needs, they were also aware of the potential for breaches in privacy linked to mothers feeling obliged to give consent for repeat examinations as part of students' learning process:

'I wonder how many women say no to an examination, particularly when they are at the demand of the student. Sometimes you can see it in their faces, that these women really would rather that you didn't do it (the examination) ... they have just had the midwife do one. I think that there are probably more women who would want to say no given the correct opportunity, because if you are student sitting there with your gloves on ready and then they are asked, how are you going to turn round and say no if the students in the room?'

(Year 3, 3 Year student)

Students suggested mothers were not confident enough to refuse students and felt pressurised into agreeing if they were in the room.

Conclusion

Students' views on mothers' privacy show similar concerns and issues as both mothers and midwives such as, concern over manners of staff, right of entry to personal space, midwives' right of observation and disclosure of information. However, there are also distinct differences. For example, students were concerned about mothers' bodies being viewed by other people and felt very protective of them in relation to this, covering them and trying to identify concerns with mothers, so as not to misinterpret the care they thought mothers required. The theme of monitoring body fluids was unique to this group, and while mentioned briefly by mothers, was not considered by midwives. This may have related to the students' role in practice where they frequently were asked to undertake skills based work, such as urine testing, as a developmental process in the early stages of their midwifery careers. As with midwives, students based their standard of practice on their own views of privacy in order to help deal with viewing bodily exposure.

The environment of care posed new difficulties for mothers attempting to maintain their privacy. Here students described an environment where open access to mothers was paramount and disclosure of information occurred both through conversations and documentary sources. Students found themselves in situations where they were party to midwives discussing cases which they considered to border on gossiping. Students in turn discussed cases within the confines of the classroom and judged this to facilitate their learning rather than breach mothers' privacy. Students also highlighted new privacy concerns in light of new technology, to include the use of video recordings.

The final influence on practice came from issues relating to their role as students. Here they suggested creating friendships with mothers helped reduce breaches in privacy, and improve what they considered to be poor bedside manners. The next chapter continues the discussion by reviewing the three data chapters to assess the similarities and differences between the three groups, mothers, midwives and students to determine how recommendations for improving privacy for mothers can be implemented into practice.

Chapter 7: Implications for Changing Practice

The last three chapters presented data collected from mothers, midwives and student midwives, the aim of which was to explore the concept of privacy in relation to mothers accessing maternity services. The research was designed to explore participants' perceptions of privacy, through their own words and actions throughout the process of pregnancy, childbirth and early mothering. What the research has provided is mothers' views on privacy within care environments, midwives' perceptions on their role in providing privacy within the confines of institutional constraints, and student midwives' views on both mothers' privacy and the working practices of midwives as they attempted to achieve privacy for mothers.

This chapter is divided into three sections; the first tells the story of privacy from the perspective of each participant group, with the predominance of discussion focusing on privacy in relation to mothers. The second section offers guidance on how this research should be implemented into midwifery practice through a review of the *Essence of Care* (NHS 2003) benchmark statements on privacy and dignity. It also outlines recommendations for practice for practitioners whose role it is to ensure that both the provision of care and the facilities available reflect the needs of service users. The final section continues by offering practical advice through a useable privacy awareness tool which midwives and students can implement into their practice to enhance privacy for mothers.

Data underpinning this section were collected from eight focus groups (plus two antenatal pre-focus group discussions) and two interviews with a total of 45 mothers, eight interviews with midwives, eight focus groups involving 67 students and eight weeks of participant observations. Each group of participants had their own views and ideals concerning privacy both for themselves and the other groups, offering an insight into not only mothers' perceptions of privacy but also how privacy was perceived by others. This next section consolidates the views of each of these groups in relation to themselves and each other.

Privacy within Care Environments: Differing Perspectives

Data from the three participant groups provided evidence of three competing ideologies which impact on the environment. Firstly, mothers perceived hospital environments as places of temporary accommodation, where they stayed until they and their baby were well enough to go

home. In comparison, midwives saw the environment as a place of employment, somewhere where they had a job of work to complete, with the aim of keeping mothers and babies safe and well. Alternatively, student midwives reflected upon the environment as a place of learning, where they observed and watched both mothers and midwives in an attempt to determine 'good practice' on which to build their own role as future midwives.

The three different participant groups in turn provided different perspectives on privacy, with mothers concerned about appearing to be good mothers and not wanting to 'lose face' in front of others, midwives considering their privacy role in relation to their working practices and students providing a story about the role of mothers and midwives suggesting that midwives did not always provide the privacy care they stated. The following section describes how mothers considered privacy as linked to the perception of themselves as good mothers and whether this perception was supported by those around them.

Loss of Face: Mothers' Perceptions of Privacy within Maternity Care Environments

Data presented in Chapter 4 described mothers' views on privacy in relation to their experiences within the maternity care environment. Underpinning these views was the mothers' need to maintain a persona in the presence of others, which purveyed the view that they were competent mothers. Where mothers considered this impression to be compromised it resulted in an interpretation that their privacy had not been achieved. This was shown to occur within Chapter 4 when mothers were observed in pain, where they were ignored or objectified, spoken to in what they perceived to be a detrimental fashion, or where they were unable to secure personal space. Privacy for mothers, therefore, needs to be considered in light of how they think about themselves and their rationalisation of how they perceive others to see them; for example, where mothers were viewed or overheard in pain their perceptions were that onlookers (or eavesdroppers) considered them unable to cope, which was then construed as an intrusion on their privacy. The underlying thread through all components was the need for mothers to maintain their personal credibility as a mother when in close proximity to others. What has been shown is that they want to present themselves to others as credible mothers who can withstand pain, labour without complaint, and care for their baby. In an emergency, where they did not perceive themselves as 'credible' as mothers, they handed over their bodies to midwives, to care-take their privacy needs and safely deliver their babies.

This section discusses how mothers perceive their privacy to be linked to what can be described as a 'loss of face' as they were viewed or watched by others during their stay in maternity wards and delivery suites. The role of community midwifery is not discussed within this section as data relating to this environment suggested that mothers remained in control of their privacy, as care generally took place within the home or GP surgeries. Although some physical contact occurred between community midwives and mothers during assessment purposes, mothers generally maintained a perception that they remained in control of their privacy. However, for the majority of mothers the first contact they had with hospital based services was on admission to delivery suite during labour.

On admission to delivery suites mothers who remained in uncompromised labour were able to achieve and maintain privacy through the midwife acting as privacy advocate and by undertaking self-introversion. Once mothers developed a sense of temporary ownership of their surroundings and gained trust in their midwife, their sense of control over their environment and their situation increased, helping to ensure they felt safe and secure. Once an environment of trust was achieved, mothers were able to handover their privacy management to the midwife who then acted on their behalf in securing privacy, by reducing intrusions, covering mothers when necessary and preventing unnecessary conversations with others. Once in this state of privacy control mothers undertook self-introversion to manage their pain. As stated in Chapter 4 self-introversion or withdrawal relates to Goffman's (1961) regression or plateaux of dis-involvement, where patients psychologically withdrew by becoming disinterested in what was occurring around them. In the case of this research mothers undertook self-introversion to disassociate from those around them, so as to focus on their body and their pain rather than disowning their body *per se*. Within this situation of environmental privacy mothers no longer considered others to be a threat to their privacy and so psychologically withdrew in order to manage their own labour in the method they deemed most appropriate. Throughout this style of labour mothers felt in control of their privacy and were able to feel competent in their actions. Participating in this normal process mothers were then able to collect their dignity '*on the way out*' and regain some sense of control over their bodily privacy post birth.

It was admission to hospital wards that created problems with loss of face for mothers. Within this environment they became vulnerable to a reduction in both visual and auditory privacy. So what

concepts did mothers consider to impinge on their privacy attainment and management within wards? Mothers perceived their inability to appear competent or credible as a mother to other people in their close proximity as interfering with their ability to remain private, with the founding principles focusing on being seen, watched or overheard by others, with the potential of discrediting their persona as mothers.

The process of being observed commences early in pregnancy, with most mothers anxious to show off their pregnancy and have it acknowledged by others, referred to as *'being proud of your bump'*. This form of surveillance was sought by mothers and reviewed as positive and considered by midwives to be useful in preparing mothers for more invasive observations and touch later in their pregnancy. However, as the process of touch increased during pregnancy mothers perceived their levels of embarrassment to reduce. By reducing the boundaries of embarrassment and its protective barrier (Jourard 1966; Jourard 1967; Richards 2001), mothers were able to participate in examinations without a sense of being violated, thus giving the impression that they were compliant during the encounter and therefore 'good' mothers.

On admission to hospital wards mothers found their credibility as pregnant mothers challenged by constantly being on view to others. The open plan design of most wards resulted in mothers having to live, eat, sleep, entertain guests and in some instances, have intimate examinations, in or around their allocated bed space, thus enhancing the potential for breaches in visual and auditory privacy. The need to maintain private space within the ward was central to mothers being able to practice the 'art of being a pregnant mother' without being viewed or overheard by others. Within maternity hospitals the social norms of public and private (Firestone 1979; Hansen 1987; Gavison 1992; Stein 1993; Scott and Keates 2004) appeared not to be applicable as mothers found it difficult to secure personal or private space within maternity wards. With the removal of day and coffee rooms mothers no longer have access to public spaces, which perpetuated bedrooms as spaces for rest and recuperation. Closure of these social spaces has resulted in mothers having to remain in, or by, their beds throughout the day, with these areas providing open access for visitors, even when mothers within the environment are subjected to treatments and examinations. Even toilets and bathrooms, usual havens for mothers as described by students in Chapter 6, no longer provided private personal space as right of entry was possible by staff monitoring the status of mothers. The result in reduction in private spaces was that mothers had to redefine their privacy

boundaries depending on their situation, similar to that described by Fahey (1995) as zoning (Chapter 2) in an attempt to attain some form of personal or private space in which they could acquire a modicum of withdrawal or solitude from being viewed, and for recuperation (Halmos 1953; Goffman 1959; Felipe and Sommer 1966; Fried 1970; Desor 1972; Pedersen 1997; Bloustein 2003; Rossler 2005). Therefore their bed-space became multi-situational, in that at any one time it could be a private space for mothers, a place in which to entertain guests, or a place where treatments took place. Because of the fluid-like nature of mothers' spatial boundaries this resulted in mothers never being sure how long their privacy could be maintained in any one given situation.

Mothers considered themselves to be watched by mothers and visitors because they were present in the locality. The usual hospital ward is set up with very little else for mothers to do apart from watching events taking place; therefore, mothers watch everything. Within the antenatal environment mothers watched each other to obtain some idea of what was to follow in the birthing process. While they were unable to witness events first hand because most mothers retired behind closed curtains, they listened to events taking place and attempted to visualise what was occurring. It was important therefore for mothers to be seen in a good light by others, with a self perception that they behaved appropriately and without making a fool of themselves in public; this included not shouting, crying or being unable to deal with pain. It could be speculated that as mothers no longer see other mothers in labour prior to admission, they have no role model on which to base their behaviour. Role models today come from witnessing births on popular television, which give unrealistic or frightening views of events in order to captivate the audience. These portrayals suggest that labour is rapid and pain free until the point of birth. There is also a social acceptance that pain is not acceptable or necessary, relating only to injury or severe illness and not a process associated with positive outcomes such as birth. In this way when mothers found themselves in labour they were unsure of how to 'perform' and felt embarrassed and ashamed of their actions, if witnessed by others (Goffman 1959; Goffman 1963; Rykwert 2001). What they tried to do was segregate themselves away from other mothers so that they were not on show, with the result that mothers were heard in labour rather than seen. Mothers therefore, perceived themselves to be 'good' mothers if they could exhibit signs to others of being able to cope with pain during labour. However, where they were seen by others as not coping when in pain, mothers perceived their privacy to be breached through disclosure of their physical inability to be a good mother. As the

majority of births involve mothers being in pain, this resulted in mothers recommending they were moved to single rooms at the point where they perceived themselves to be in labour so as not to be overheard or seen by others. This would then enable them to 'perform' how they wished without compromise.

While not being seen by others was deemed important by mothers, being overheard had the potential to make personal information available to a wider audience. Mothers admitted to antenatal wards acknowledged their desire to observe other mothers on the ward, as a means of determining courses of treatment or treatment outcomes. However, it was the act of being viewed themselves which they resisted, particularly where they considered it to compromise their bodily privacy.

Disclosure of personal and physical information was considered by mothers to be detrimental to their ability to retain 'face' in front of others. The more revealing information another person had about them, the more they perceived their privacy loss to be. While disclosure of information within healthcare settings is crucial to the receipt of appropriate care (Back and Wikbald 1998), control of that disclosure is central to mothers' perceptions of the control they have over their autonomy and privacy (DH 1993). Disclosure of any sensitive information has the potential to result in emotional harm to the person, ridicule, deprivation of rights, relationships or social standing (Badzek *et al.* 1998). In most instances it was the way in which the information was subsequently handled following disclosure that had the potential to determine mothers' level of perceived invasion of privacy (Lazarus 1969). Both mothers and midwives expressed a dislike of having their personal information disclosed to others, however, for mothers the potential for others to gain access to their information was no more evident than in antenatal and postnatal wards. Within these settings personal information could be overheard by eavesdroppers, through inadvertent conversations or discussion of cases, or seen via conduits such as, records, video recordings or notice-boards. Mothers were also concerned that staff discussed their details in open spaces, even when enclosed areas were available, resulting in disclosure of their personal details.

Trying to remain credible within the ward was difficult for mothers when staff openly breached confidentiality of mothers by disclosing their information. Mothers gave examples of midwives and in some instances doctors, shouting down wards, having detailed conversations at nurses' stations in earshot of other mothers and having loud and inappropriate conversations at the end of mothers' beds. All of these discussions mothers considered to be disrespectful to them and has been shown

in previous research to be detrimental to psychological wellbeing resulting in a lack of respect for staff (Barron 1990; Rylance 1999). This disclosure resulted in mothers having the perception that strangers within the ward then held information about them, over which they then had no control, the level of privacy breach relating to the potential risk of personal information being available to others.

The idea of other mothers having information regarding them, mothers found difficult to manage within hospital. These mothers were perceived as strangers and as one mother described *'not the sort of people you want to be seen in a bar with'* and certainly not to socialise with (DeCew 1997; Cohen 2001; Cooper 2003). Because of this mothers attempted to segregate themselves from others by pulling curtains or ignoring those around them. The idea of engaging in social interaction and discourse with strangers did not appeal to mothers, who generally expressed a dislike of this approach, wanting control over when and if, to interact with others (Inness 1992; Boling 1996). This resulted in mothers not wanting other mothers or their visitors to have access to their personal information and certainly not their innermost physical information.

Part of the difficulty with maintaining face was other people overhearing during examinations and procedures. Overcrowding within wards and the lack of suitable accommodation in which to undertake procedures, such as, induction of labour or vaginal examinations, resulted in procedures being performed in open wards, behind closed curtains. In these situations curtains offered some visual privacy for mothers during these procedures, but did little towards offering auditory privacy (Burden 1998). Mothers, therefore, found themselves having vaginal examinations behind curtains, often during visiting times, with the whole process being explained in graphic detail by the midwife, whose goal it was to keep the mother as informed as possible. While midwives expressed concern at having to perform examinations on mothers during visiting times, they felt compelled to do so because of their duty of care. However, this raised an issue of time management, particularly as mothers require so few physical examinations and therefore if care was well organised, it could be anticipated that such examinations could be undertaken at times other than during visiting. The perceptions of mothers within the study were that no matter how discrete midwives attempted to be during these procedures, when the curtains were drawn back, other people within the room (usually visitors) had received a graphic explanation of events, and therefore had intimate knowledge of mothers' bodies. It was disclosure of this knowledge that mothers found extremely embarrassing,

perceiving this to be as problematic as having the examination performed in public (Schneider 1977).

Disclosure of personal information through breaches in auditory privacy also resulted through eavesdropping and overhearing. Eavesdropping is usually associated with covert surveillance of unsavoury characters or reporters (Young 1978; Rossler 2005) and is perceived as detrimental to the person being listened to because of its ability to reveal intimate secrets regarding the person (Prosser 1960). Mothers' within the study used eavesdropping as a method through which to gain information on care processes but more importantly to listen to interesting stories about other mothers' medical and social problems. Mothers gave accounts of overhearing other mothers describing their labours to their own mothers over the telephone, of a new mother having to explain an undiagnosed pregnancy to her mother and mothers attempted to deal with problems at home over the telephone. These accounts added to discussions with staff when they stood at the ends of mothers' beds, made for interesting listening. It was these activities which had the potential for greatest disclosure as they were stories which made for interesting telling and therefore were more likely to be told to others with the outcome of mothers feeling isolated and vulnerable as their personal information was made public.

The use of technology also had the ability to result in mothers feeling compromised as, when used, mothers considered themselves to be ignored during encounters with staff. This was particularly evident in the use of cardiotocograph equipment (CTG). Mothers explained how staff appeared more interested in 'interacting' with the machinery than with them. Under these circumstances mothers explained how they felt ignored by disrespectful staff who considered them too 'stupid' to be involved in the technical discussion. The key factor here is that mothers were well, but medicalised and treated as unable to participate (McKinley 1972). This process of objectification is known to result in patients feeling invisible and violated, with staff subsequently neglecting their privacy needs (Applegate and Morse 1994) and treating them as inanimate objects (Vail 1966). When midwives were challenged on why this happened to mothers, they related this to poor practice and to the personalities of midwives or doctors. However, what was not evident within focus groups, interviews or participant observations was, why, if midwives knew this practice of ignoring or depersonalising mothers took place, they did not subsequently intervene to act as advocate for mothers, particularly as they frequently stated they adopted an advocacy role?

Objectification initiated by staff resulted in different outcome for mothers. Within the study mothers, students and midwives all described how at some stage in their lives they had been in a situation where practitioners had dealt with them as objects, rather than individuals. Stories were told of doctors talking to partners about football scores, the size of tears, answering telephone calls or even leaving the room while a mother was left exposed during a speculum examination. In all cases participants objected to the approach describing how they felt angry, violated and humiliated and as one mother stated, feeling 'stupid'. Students within the study even described how doctors treated mothers like 'pieces of meat'. This begged the question, if midwives and students had experienced this type of care, why did they not act upon it to stop it happening to mothers?

Midwives appear to have difficulty asking doctors, or in some cases colleagues, to discontinue this activity, although there is no evidence within the research to clarify why this was so. It could be speculated that due to the power relationship between midwives and doctors they perceive themselves to be subservient, suggesting therefore, that privacy attainment maybe influenced by individuals as well as situations.

Objectification was also seen in situations of emergency, presenting in two forms; firstly where mothers chose to disassociate from their body in order not to hinder the work of professionals, subsequently called self objectification or inanimation and secondly, objectification of mothers by staff (Vail 1966; Gubruim 1975; Strong 1979; Frankel 1983; Heath 1986). Where mothers considered themselves unable to act as a good mother and deliver their baby normally they withdrew into their bodies becoming inanimate or disassociated. Here they could ignore external influences and gain control of their privacy once the event was completed, with a sense that their privacy was maintained throughout. In this instance mothers disassociated themselves from their bodies, in order not to interfere with the actions of practitioners attempting to assess or deliver their baby. By lying completely still and not participating mothers left practitioners to deal with the emergency unimpeded. The mothers' rationale for non-participation being that if they interfered in any way this may compromise their baby further, or hinder practitioners in their work, so they suspended their privacy needs as their baby's safety became paramount. By disassociating from the situation mothers were able to consider the event as something happening to 'their body' rather than to them. This enabled them to maintain their role as mother by acting in a way that enabled

practitioners to do their job, while considering themselves as unable to continue in the role because of factors outside of their control.

During complicated cases the number of people present within the delivery room increased significantly with midwives reporting extra staff there to watch (Goffman 1961; Goffman 1963; Kelvin 1973). The number of people present in delivery rooms increases mothers' sense of being watched and of being unable to address this. Being watched under these circumstances is linked to degradation and vulnerability of the person (Arendt 1958; Westin 1970; Schneider 1977; Lawler 1991) and so occasionally midwives would ask people to leave the room, particularly if they were perceived to be superfluous to requirements. However, mothers described staff as being desensitised to mothers' bodily exposure and unconcerned by the number of people who appeared to be able to view them at this time. This was seen during the incident on the delivery suite, where an extensive team of people ignored the naked mother for some time at the end of a caesarean section, even though she was visually exposed to people walking along the adjoining corridor. The act of lying naked while being aware of people within the room mothers described as humiliating. Not being able to manage nakedness or have this addressed by others resulted in them considering themselves to be 'slabs of meat' in the eyes of practitioners and as not worthy of privacy.

Following the birth of their baby mothers were admitted to hospital wards where they were met with situations of overcrowding in the environment and authoritarian staff resulting in them feeling watched and treated with disrespect. Overcrowding has been shown (Chapter 2) to reduce concentration, task completion and task competency (Freedman *et al.* 1971; Freedman *et al.* 1972; Jain 1987; Rustemli 1992; Pattison and Robertson 1996; Kaya and Erkip 1999), and increase aggression (Nijman and Rector 1999), all of which, it could be argued, can influence the development of good mothering skills. The problem with overcrowding was the dilemma this evoked in mothers; generally they wanted open access for their own visitors, while being uncomplimentary of other residents' visitors. The drive for new mothers was the need to 'show off' their new baby to gain praise from family and friends. Mothers found themselves adjusting to their role as 'new' mother while being 'told off' by staff. Here the drive for mothers was to appear protective and competent when dealing with their baby in front of visitors and staff. This made

breastfeeding, in particular, difficult for mothers where they felt unable to master the technique and therefore could not 'perform' adequately in front of others.

In comparison to hospital wards, the small number of mothers within the study who had homebirths created a picture of a homely, relaxed environment, where they took charge of their own care, wore their own clothes, visited their own bathroom and slept when they wanted, enhancing personal autonomy and privacy control. Here mothers felt in control of their situation, with midwives perceived as guests or visitors, a reversal of the hospital roles and similar to that experienced by district nurses (Magnusson *et al.* 2002). The notion of the homebirth as privacy ideal was perpetuated by midwives and students who perceived this as providing the 'ideal' form of privacy care they could provide for mothers.

All three groups of participants described how giving mothers a choice throughout their contact with the maternity services enhanced their perception that their privacy was being addressed and was within their control. This included choice, both in care but also when and if, to interact with other mothers or visitors. Choice was also linked to being involved in conscious decision-making while being kept informed (DH 1993). Mothers' sense of ownership of their body and of surrounding events was enhanced by having a positive perception of control over, events, situations, care and interactions. Part of this positive perception was linked to mothers' ability to reflect upon their experiences and adapt these to current ones. Choice and control were considered by mothers to be promoted through the development of a trusting relationship with midwives, where midwives acted as advocate in situations when mothers could no longer control events or circumstances. Midwives confirmed this by suggesting that where they retained control of mothers' care, without interference from others, mothers were more likely to have the privacy they required.

Being treated with respect, dignity and courtesy while accessing the maternity services helped mothers achieve a positive privacy experience. Part of this process mothers considered to be linked to appearing competent, either when in labour or when trying to develop their competence as new mothers. Where mothers perceived staff considered them as incompetent they felt this opened them to bodily intrusions by staff, such as grabbing mothers' bodies.

Where their body or information about their body was witnessed by someone else, mothers in the study associated this with a perceived loss of face (Bloustein 2003). Loss of face, or in theoretical terms, defamation of character, is generally associated with an injury to a person's standing or reputation within the community (in this research a mother's standing within her immediate community of mothers), and involves injury to the person's perception of herself or her emotional tranquillity, and in this instance being perceived as a poor mother (Prosser 1960). In order to enhance mothers' perceptions of privacy, care must be geared towards creating an environment where they felt confident and competent in their mothering ability. By reducing their sense of being watched or listened to and by treating them with respect by talking to them, gaining their trust and consent, mothers considered their privacy needs as being addressed rather than ignored.

Midwives' Views on Privacy in Maternity Care Environments

Midwives' perceptions of privacy within maternity care environments were based on the notion that mothers were visiting their working environment, so whatever privacy care mothers required needed to be compatible with that notion. While midwives described their views on the ideal environment, which was 'homely' and spacious, reflecting similar ideals as mothers, they considered this as unachievable and unrealistic in light of current constraints of overcrowding, staff shortages and high turnover of mothers. Midwives continued by suggesting wards could never be homely because their primary function was as a place of work, where clear targets were applied which staff were obliged to achieve, particularly in relation to standards and type of care provided. On discussion midwives described their ideal view of a maternity ward, suggesting a homely, friendly environment where partners could stay to support new mothers. They suggested that if this was not possible then mothers should stay at home as long as possible when in labour and go home as quickly as possible, following the birth. Even within these constraints midwives considered themselves to offer the best service they could base on their own privacy expectations and practical skills. These practical skills included techniques for covering mothers to prevent intrusions of bodily privacy and ensuring access by intruders were kept to a minimum.

As with students, midwives related the privacy needs of mothers to their own experiences, needs and inhibitions, using these as foundations on which to base care provision. They adopted a range of strategies in an attempt to ensure privacy, to include; professional distancing or not becoming too familiar with mothers in order that invasive procedures could be performed without a sense of

guilt, and creating and developing relationships where midwives could then act as advocate for mothers to make them feel at ease during examinations.

Midwives within the study often cited their advocacy role as inherent in the process of transposing their own privacy ideals onto mothers. Transposition was undertaken in an attempt to provide privacy care midwives knew *they* would want, and therefore, felt sure mothers would prefer. It could be envisaged though, that as with views on privacy in general, everyone's views on privacy differ and therefore what is perceived as a suitable standard of care for one mother, may not be suitable to another. In this case, unless midwives directly explored privacy requirements with mothers, it resulted in a privacy plan which reflected the privacy needs of the midwife, rather than the mother.

Transposing privacy ideals for both midwives and students was based upon their philosophy of practice of *'treating others as you would want to be treated'*. While this has the groundings of a good personal philosophy, in light of the comments above it would need to reflect a social discourse with mothers to ensure it encapsulated their privacy requirements. It was interesting to note that student midwives reflected upon this philosophy for practice, by considering midwives to be immune and disassociated from mothers and therefore unable to transpose themselves into the mothers' situation. They continued by suggesting midwives actually did the opposite and dehumanised mothers as a coping mechanism to enable them to undertake physical examinations, without feeling embarrassed (Goffman 1961; Misago *et al.* 2001). By dehumanising mothers, students suggested midwives separated the 'person' from the 'body' and thus were able to treat them by touching and assessing the 'body' without compromising the 'person' (Scott and Morgan 1993; Henslin and Biggs 1995). However, when this was discussed with midwives they stated how they separated not the body from the person, but their work practices from their home life (Burke 1945) thus ensuring the two were not compromised.

Midwives were aware of their professional and statutory duty of care to mothers and considered this to override any specific privacy requirements mothers made which were not compatible with this outcome. They described how they acted on behalf of mothers in an attempt to balance their privacy needs with their professional need to observe them within a busy working environment where staff shortages were evident. Midwives discussed their role in observing mothers and thus the role in played in breaching visual privacy. However, this was linked to their duty of care to

observe mothers (Foucault 1973). For example, midwives outlined how mothers pulled curtains around beds to seclude themselves from others, with this proving problematic for midwives because of their duty of care to observe mothers, with the outcome that problems could be missed. As stated earlier, in the current climate of staffing shortages and overcrowding the need to view mothers has become more apparent.

Midwives disliked overcrowding because of its impact on their ability to observe mothers. As wards have become more crowded, the distance between beds more compacted, and the number of midwives declined, midwives have found it more difficult to be continuously 'with' mothers. This has resulted in them needing to view mothers from a distance, often at a glance, and in extreme cases via Videocam surveillance from a central viewing desk, rather than spending time directly within the mothers' vicinity (Agne 1994; Ferguson and Wadham 2003). In previous years midwives would have worked using client allocation, with midwives allocated to small groups of mothers. However, today's midwives find themselves unable to be allocated to groups as there are too few midwives with which to adopt this approach. This has resulted in all mothers being viewed by smaller groups of midwives with the result that midwives have a need to be able to see mothers at a single glance. In this way it could be suggested that as midwives are used to caring for mothers, they perceived their role as managing privacy for mothers rather than as facilitating or enabling mothers to manage their own needs, thus adopting a more maternalistic approach to caring (Lawler 1991; Porter 1992; Whitbeck 1993; Bolton 2006).

Midwives described how they moved into a privacy management role to prevent intruders from witnessing mothers' nakedness, considering they took responsibility for ensuring mothers remained covered during procedures. This was important to midwives as they were conscious of extraneous factors within the environment, of which mothers were unaware, which could have breached privacy, and thus they maintained a sense of heightened awareness of imminent intrusion violations. Because they knew intrusions occurred they attempted to reduce such incidences by using signs, notices and privacy curtains, but even so, were not convinced that these were effective.

Mothers within the study described how midwives tried to keep them covered during examinations, to protect them from being seen if an intruder entered during the procedure and to help maintain a

sense of dignity during the process (Williams 1991; Barber 2001; Gallagher 2001; Matthews and Callister 2004). The impression given reflects the notion of vaginal examinations as 'dirty' and covert and something which should not be witnessed by others (Henslin and Biggs 1995; Mattiasson and Hemberg 1998; Bolton 2006) and therefore steps had to be taken to prevent others knowing they were taking place. One way of attempting to ensure mothers remained free from bodily exposure were the techniques, midwives, and to greater extent students, adopted to cover mothers. In comparison, covering mothers was perceived by students as a role which helped ensure they participated in care provision. Students described how they actively promoted covering of mothers, as they felt this aspect of care was neglected by midwives, seeing it as a role which they could readily adopt.

Part of the midwives professional need was to discuss cases in which they were involved. Midwives within the study did acknowledge discussing cases but told how this took place within confined areas such as, coffee rooms where confidentiality could be assured. Where confidentiality was brought into question they told how they did not use names of mothers when reviewing cases, reverting to calling mothers 'their lady'. Reviewing of cases was perceived by midwives to be crucial to the development of their practice. They described how they shared information on cases with other colleagues as a method of ensuring that their practice was within normal limits, with group discussions helping to develop group solidarity (Bolger 1985), group inclusion (Moore 1984; Moore 1998) and daily working. However, students described how they perceived much of this to be nothing more than gossiping, which they considered to be rude and disrespectful to mothers. In spite of this students perceived this to be a human trait and therefore agreed it was not the act that was the problem, but who was available to overhear it in the venue in which the gossiping occurred.

One of the methods midwives considered would help mothers retain their privacy was to transfer them home as soon as possible after the birth or keep them at home as long as possible when in early labour. This appeared to conflict with discussions offered by midwives where it was reiterated that it was essential for mothers to be around their peers, particularly after the birth, to enhance peer learning and provide a support network of new friends. Midwives felt strongly that mothers remain in close proximity to each other, with bed curtains pulled back, so that social interaction, peer support and learning could take place, even though this was generally considered

unwarranted by mothers. Being around others midwives also considered included partners, particularly as they were concerned that partners needed to have time with mothers following birth, to promote bonding as a family. During this bonding process midwives believed mothers' to want personal space, in which bonding with their baby could take place and sympathised with the difficulty of achieving this within the confines of the ward.

Students' Perceptions of Privacy In Maternity Care Environments

Within the study students were in a unique position, being able to watch mothers while reviewing midwives' practice. In relation to this project this enabled them to offer views on privacy from their own experiences as mothers and also from working with mothers, their views on the working practices of midwives in their role as soon-to-be midwives and their own practices as students.

Students' views on mothers' privacy were associated with practical issues such as, collection and storage of specimens, bodily exposure and overcrowding. In comparison midwives, they suggest, were desensitised to their work seeing it as 'just a job', making them complacent with regards to attitudes, confidentiality and promoting choice. Lastly, students offered a view on their own role as students suggesting they adopted a skills base approach to their work, which involved covering mothers, talking to them and acting as privacy monitor, particularly as they considered midwives no longer wanted to be involved in these aspects of care (see Chapter 6).

Students based their assessment of privacy on their own experiences and needs as women and in some cases, mothers. By presenting their evidence on mothers underpinned by this experience they considered this to add credibility to their debate. The results were that students gauged whether or not mothers' privacy had been breached based on their own perception and experience of similar events. This enabled them to gauge the level of concern mothers may have about that encounter against their own privacy standards; however they considered themselves constrained by their role as students and so unable to address mothers' privacy on their behalf unless through task completion. This resulted in students undertaking tasks that they knew they could achieve, such as covering mothers and dealing with specimens.

Students considered mothers to be concerned about having to show parts of their bodies, 'dirty' sanitary pads or samples to midwives as they considered these were embarrassing. It is interesting

to note, given the potential importance to privacy, that only mothers (somewhat briefly) and students discussed body fluids. It could be contemplated that mothers were too embarrassed to discuss them and that midwives too desensitised through their professional experience to consider them an issue. Students however, would be dealing with these samples on a daily basis because of their role in learning about these as sources of complications during pregnancy and birth and so were very practical in their approach to privacy.

Using basic skills, such as covering mothers, was a role adopted by students within the study. There appeared to be a dichotomy between students' and midwives' perspectives on this task, with students considering it unimportant to midwives and therefore they acted on behalf of mothers by taking over the task. However, midwives within the study acknowledged covering as important to their practice and considered it part of their role. Students incorporated their own personal and professional experiences into their practice by imagining themselves in mothers' situations, providing care they thought mothers required in similar circumstances. This process was comparable with the views of midwives. However, the discussions outlined by students suggested they were less distanced from the process and better able to use an imaginative approach to their practice. They also acknowledged how they watched the practice of others adapting their own skills, based on what they perceived to be best practice. This was particularly evident in relation to what students considered to be the role of good 'bedside manners' in promoting privacy, such as asking permission prior to undertaking care.

On discussion, students considered midwives' ability to help mothers achieve privacy were linked to their attitudes and general manners. They described good practice where students were asked by midwives to leave rooms during examinations when too many people were present or care was routine, as opposed to poor practice where staff did not knock before accessing mothers' rooms or ask permission to touch. Students suggested that mothers also disliked being talked over or ignored during examinations. One explanation given by students for this taking place was that midwives had become desensitised to the privacy needs of mothers because of their daily work with naked mothers, relating their practice to 'just a job'. They also outlined how they considered midwives to be under considerable pressure to do 'the job' resulting in them observing all mothers, irrespective of complications. They also felt midwives had little regard to maintaining mothers' confidentiality (as did mothers) as they frequently gossiped about them within open areas, where

conversations could be accessed or overheard by others. This gave students the impression that midwives 'owned' the clinical area and therefore felt it was within their rights to discuss cases and it was actually the fault of the third party, if they 'happened' to overhear. Students also perceived midwives to believe they gave mothers choice in the type of care they were offered. However they suggested this was not the case, particularly when partners were involved when mothers' ability to choose was reduced and midwives actively involved partners in decision making even if mothers had not requested this.

In order to deal with privacy in care environments in these circumstances, students suggested mothers became compliant and submissive to midwives. Being submissive or disowning their bodies was seen by students as an attempt to justify allowing midwives to perform procedures, and was perceived as central to helping mothers deal with the process of birth. Students felt that mothers' attitudes towards privacy changed with each subsequent pregnancy, so as mothers returned for second and subsequent births, they were less inclined to worry about privacy, particularly in relation to their bodies.

Students were particularly aware of their role as students and the impact this had on privacy for mothers. They were aware of their own inexperience in relation to midwifery practice and felt this resulted in breaches of privacy, just because they were unaware of their actions or the impact of their surroundings on the task and more specifically because they had to perform additional examinations on mothers in order to learn. Students also described their need to review cases as part of their development which they were concerned could be construed as gossiping or as breaching disclosure privacy. In these circumstances students described discussing cases within the confines of the classroom and with pre-determined ground rules, which they felt ensured protected the confidentiality of mothers and reduced discussions outside of this environment to a minimum. In this way students felt enabled to learning from cases without disclosing mothers' personal information.

There were also differences between the perceptions of privacy between the three groups. While mothers were concerned with overcrowding, saving face and problems with disclosure privacy, midwives highlighted problems with ensuring privacy for both partners and mothers when partners were present, being unable to control entry to their working space by others and needing to discuss

cases within the environment. Students on the other hand focused on information sources as a possible privacy breach, particularly in relation to notice-boards and records. However, they also discussed issues relating to partners taking video recordings, particularly during the birth where they felt mothers did not openly agree for this activity to take place. It could be anticipated that couples would discuss recording the birth before the event. However, in reality mothers' feelings towards this activity changed once the true nature of the event was considered. They also described issues relating to disclosure privacy which they felt were in reality midwives gossiping, even suggesting that although midwives felt this was reflecting on practice, what was actually occurring was social gossiping.

In summary, what has been shown within this research is how privacy differs for individuals in relation to: the impact of the environment, bodily exposure, the situation in which the individual finds themselves, the people they come into contact with, whether they can be seen and whether their personal information moves into the public domain. The underlying thread through all components is the need for mothers to maintain maternal credibility when in contact with others. What is shown is that they want to present themselves to others as credible mothers who can withstand pain, labour without complaint, and care for their baby. In an emergency where they cannot be 'credible' as a mother, they hand their bodies over to midwives to enable them to safely deliver their baby without hindrance, as caretaker of their privacy needs. In response to this approach mothers want to be treated with dignity and respect, not as stupid or ignored and do not want to be talked about in public places. By building trust with their midwife, mothers want to remain autonomous throughout pregnancy and birth to maintain a sense of control over their privacy. The next stage of this research was to offer advice on how practice could be developed to enhance privacy for mothers within maternity care environments. The next section commences by reviewing existing guidelines on privacy for healthcare professionals, offering recommendations for extending them into maternity care.

Revisiting the Essence of Care Benchmark Statements: Recommendations for Improving Practice

In order for this research to be effective in producing change it needs to be incorporated into practice and as the document, *Essence of Care* (NHS 2003) offered guidance on benchmarks for privacy care it was deemed a good starting point through which to determine current standards.

The benchmark for Privacy and Dignity, relevant to this study (outlined in Chapter 2), is sub-divided

into seven factors of good practice. In light of this research these statements were re-visited to see how they could be improved by new knowledge and subsequently applied to midwifery practice. While it is acknowledged that the findings of this study may not be generalised to a wider population, because of the limitations of the sample, they are discussed here in relation to supporting the existing statements, building upon their recommendations.

The first factor, *'Attitudes and Behaviours'* relates to the benchmark which considers *'patients feel that they matter all of the time'*. The indicators of this factor recommend that good attitudes and behaviours are promoted, particularly towards minority groups, including both non-verbal behaviour and body language. It recommends that partnerships exist to support good attitudes and behaviour, although not stated it is presumed this is between staff and patients. In relation to this research good attitude and behaviour of staff were identified by mothers within the study as necessary for development of partnerships in care and for increasing staff's ability to protect privacy. However, this does bring into question how the term 'good attitudes' is defined? Information specifically relating to minority ethnic groups was not considered within this research and should be explored through additional studies. In light of data from this study the following areas are suggested for inclusion; that staff promote a high standard of social etiquette, such as seeking permission prior to treatments, knocking on doors, waiting for consent to enter rooms, and not talking 'across' patients. Secondly, while 'good attitudes and behaviours' should be promoted, it is important that they are promoted in an environment where staff are not patronising and authoritarian and where they work in partnership with mothers.

Factor 2 relates to experiencing care in *'an environment that actively encompasses individual values, beliefs and personal relationships'*, addressing issues such as challenging stereotypical views, valuing diversity and the need to ascertain and review individual needs and choices. All data groups within the study acknowledged the uniqueness of privacy to individuals and considered choice as central to mothers' sense of autonomy (Gross 1971; Feinberg 1983; Graneheim *et al.* 2001). The following additions are therefore recommended; midwives should assist mothers to reflect upon and take control of their circumstances, promoting choice and control over, events, situations, care and interactions, to enhance privacy. Also, mothers should be involved in decision-making processes to facilitate their involvement in privacy care and as shown in this research, enhance self worth and autonomy.

Factor 3, *'Personal boundaries and space'* relates to the benchmark which states, *'patient personal space is actively promoted by all staff'*. This includes agreeing the name patients should be addressed by during admission, determining their acceptable level of personal contact (touch), and the identification and communication of patients' personal boundaries to others using their own language. Individuals' personal space should be respected and protected and strategies put in place to prevent disturbing or interrupting patients. The benchmark also recommends that privacy is effectively maintained through the use of curtains, screens, walls, rooms, blankets, appropriate clothing and appropriate positioning of patients, and includes the provision of single sex facilities. There is also a recommendation that privacy is achieved even when other people are required to be present. More controversial is the notion that privacy should now be dealt with in relation to clinical risk assessments. While the majority of the above indicators are supported by this research, a number of additions are again recommended. As supported by data in Chapter 4 mothers should be able to bring their own personal belongings with them into hospital to help promote a sense of belonging within the immediate environment. Personal space should be available to new mothers and their partners on postnatal wards, to promote bonding as a new family without interruptions or intrusions, and ward environments should accommodate no more than two residents, so any sense of overcrowding is reduced. Mothers should be introduced to other occupants on admission (where possible) to help facilitate social interaction. Space should also be made available for mothers to meet visitors away from the ward environment, such as in, sitting rooms or coffee areas, so that bedrooms remain places where mothers can rest without interruptions. Partners should also have access to personal space on delivery suites which is separate from that of mothers in order that they do not impose on their personal space.

Factor 4 relates to the benchmark, *'Communications between staff and patients takes place in a manner which respects their individuality'* and includes indicators relating to developing translation and interpretation services, adapting information to meet the needs of individual patients and maintaining appropriate records of communication exchanges. There were various communication mediums discussed within this research which impinged on disclosure privacy, to include, records, notice-boards, and group discussions. However, details relating to translation and interpretation services were not addressed by any of the groups and as stated earlier will require further research. Issues identified within this research but not obvious in this benchmark include, reducing

inappropriate discussions between staff within hearing distance of mothers. Mediums for communication should be monitored to ensure breaches of privacy are minimised, for example, notice-boards should not be placed in public areas, all communication must facilitate mutual respect for the person and not be patronising, and discussions should not take place across mothers or without their involvement. Mothers should be listened to so as to determine their privacy needs, rather than having them based on midwives' own experiences or inhibitions. Staff should develop working relationships with mothers that are supportive and based on mutual respect and equality to enhance autonomy. Where high standards of privacy care are identified these should be disseminated to colleagues to promote good practice.

Factor 5 relates to the benchmark which states, *'patients information is shared to enable care, with their consent'* and includes the following indicators, that informed consent is gained when special measures are needed to overcome communication barriers, precautions are taken to prevent information being shared inappropriately (examples given include, telephone conversations being overheard, computer screens being viewed and white boards being read); and procedures are in place for giving or receiving patient information (at handovers, consultant and or teaching rounds, admission procedures, telephone calls, calling patients in outpatients and breaking bad news). In addition the following recommendations are made for inclusion in the statement. Information exchanges between practitioners or between practitioners and mothers must be undertaken away from other residents and visitors and similarly, discussion of cases by staff should be undertaken in environments where overhearing by mothers, visitors and other practitioners cannot occur. For example, no conversations of an explicit nature should be undertaken behind curtains in wards. Because of the possible implications of mothers overhearing staff gossiping about patients or staff care should be taken to eliminate gossiping in clinical areas. When documenting personal information in client-held notes, care should be taken to reduce exposure of sensitive information to others, through the use of complementary records. The use of visual recordings should be agreed by all parties, including staff, mothers and partners so that the outcome of possible disclosure of information is realised. Mothers should not be able to hear the pain or distress of others and as such, designers of maternity hospitals should consider a move towards single room accommodation for mothers, particularly for those in early or active labour.

Factor 6 relates to the benchmark which states, '*patient's care actively promotes their privacy and dignity, and protects their modesty*' and includes the following indicators, patients are protected from unwanted public view (by using curtains, screens, walls, clothes and covers); patients have access to their own clothes, and where is this not possible appropriate clothing should be available; patients' can have private telephone conversations; and modesty achieved for those moving between differing care environments. These indicators were discussed by mothers within the study and it is important that emphasis is not placed on the use of curtains as a finite source of privacy management for mothers on wards, because of their inability to provide complete privacy from visual or auditory intrusions. The benchmark should be extended to include the following; the use of chaperones should be discussed with mothers on admission so that they are given the choice as to their use, if required. The role and presence of partners during intimate examinations must be discussed on admission, to ensure their role and presence during these events are agreed between all parties. Observers must be kept to a minimum during intimate procedures to reduce mothers' sense of voyeurism, to include ensuring that students gain permission to be in attendance prior to observation episodes. Because of the possible intrusions into mothers' bodily privacy, invasive procedures must not be undertaken during visiting times unless mothers are removed to treatment rooms, or there is an emergency or clinical need and where this is not practical practitioners should not explain the process or findings of examinations during procedures, to ensure others are unable to visualise the event. It is important that practitioners acknowledge and abide by strategies adopted by mothers during intimate procedures and emergencies, such as, self-introversion and self-inanimation, because of the role they play in enhancing mothers' perception of privacy maintenance. Practitioners must also act as advocate for mothers, to ensure that in periods of compromise their bodies are not exposed to the gaze of others. The handling of body parts, particularly during breastfeeding, should be kept to a minimum by practitioners and consent obtained before initiation. The management and disposal of body fluids should also be completed in an environment of discretion and respect. It is important to note that there is no discussion on the handling or viewing of body parts or fluids within *Essence of Care* and their inclusion reflects the perceptions of mothers and students within this study.

Factor 7 factor relates to the benchmark which states, '*patients and or carers can access an area that safely provides privacy*' and is reflected in the following indicators, private areas are created in patients' home as well as in health service settings; patients are aware of the availability of a 'quiet'

and or private space and how this is achieved; private areas are available; clinical risk is handled in relation to complete privacy. These indicators can be expanded through the following additions for maternity environments, to include; mothers should have rooms available that meet the needs of their stage of pregnancy, for example, segregation of mothers in labour, ensuring quieter rooms for new mothers, and rooms where partners are encouraged to participate in caring for mothers and babies. Mothers should have personal space in which to practice and develop new skills and competency, for example in, breastfeeding, pain management or developing new mothering skills, without perceived criticism from staff or other residents. Single rooms should also be made available to mothers when in early labour to reduce the risk of being observed or overheard by others. Examinations should not be performed in ward areas, but in specially designated treatment rooms.

As with the development of any new standard is it necessary to consider the mother or client during their design and in relation to privacy; it is important to consider that every individual has different privacy needs and ideals and therefore it is difficult to be prescriptive in the approach. On admission to wards and delivery suites midwives should undertake a privacy assessment on behalf of mothers and their partners to ensure the environment and procedures to be undertaken are considered for their ability to disrupt personal privacy of mothers. The assessment of privacy should relate to the needs of mothers, utilising knowledge of their requirements, so that the plan of care is individually specific and considered in relation to the clinical area in which mothers present.

One of the original aims of the research was to design or create a model of privacy which could be used across the maternity services. However, what was designed was a useable tool which could incorporate the information outlined above so as to provide a situation specific tool, that had been individualised for specific mothers, as will be shown in the following section.

Developing a Privacy Tool for Practice

One of the original objectives was to develop a privacy model. So can a model of privacy for maternity care be created and if so what would it look like? If we look back at the literature in Chapter 2 various models have already been proposed, ranging from Fahey's zoning (Fahey 1995) to Rossler's (2005) onion model, usually with each author applying their model to their subject discipline (Westin 1970; Young 1978; Kelly 2003). While in some respects this is rather incestuous,

there are underlying principles of privacy which can be utilised across disciplines, and supplemented by characteristics of privacy in relation to the environment in which it is studied. Within this study there are common elements emerging which have similarities with other literature on privacy, such as withdrawal (Barrett 1995; Evans *et al.* 2000), isolation (Halmos 1953; Inness 1992) and the need for 'good manners'. These fundamental components underlie the principles associated with privacy and are likely to be widely shared, while the detailed interpretation and application of how to support them is likely to vary. There are also new concepts emerging from the data which also need to be considered in relation to other areas of good practice, such as improving attitudes of staff and self-introversion. Any tool created must consider the multi-faceted nature of privacy in relation to individual's needs, their needs at a specific time, the environment in which they are sited, the reason for the individual being in the environment and surrounding influences. All of these things make it difficult to design a single model of privacy, as each person and their needs are unique. However, there are commonalities within therapeutic encounters between mother and midwife and across procedures, for example, needing to ensure visual privacy, not talking about personal or physical issues behind curtains (disclosure privacy), moving mothers to single rooms for procedures and not handling mothers without consent.

Therefore, what I wanted to create was a practice model which could be situational, individually specific and easy to use for midwives and in relation to individual cases. While various models were designed and explored the following diagram (a segment approach) was used to produce a skeleton model into which a midwife, on consultation with mothers, could add unique privacy components for that individual, as related to the impending procedure. Each segment would be completed (where possible) on discussion with the mother to ensure that all her privacy needs were addressed. What was envisaged is that by accumulating these models over a period of time the outcome would be a repository of models highlighting both commonalities of privacy and items which were unique.

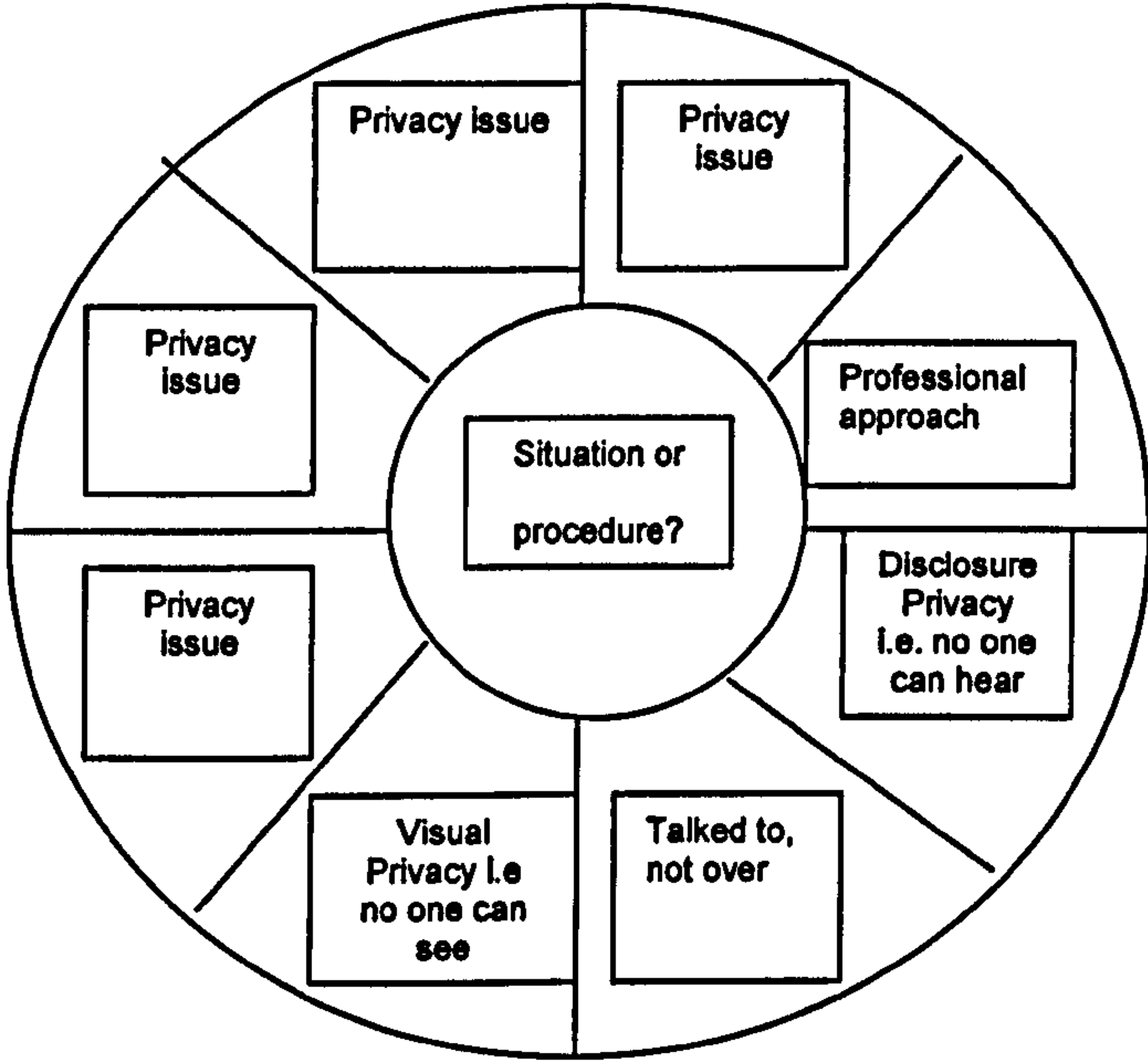


Diagram 7: to show the segment model of privacy needs template

In the example given below, the diagram has been completed to show the constituent components of privacy relevant to a vaginal examination. In this instance reviewing the issues involved enabled the segments of the model to be completed.

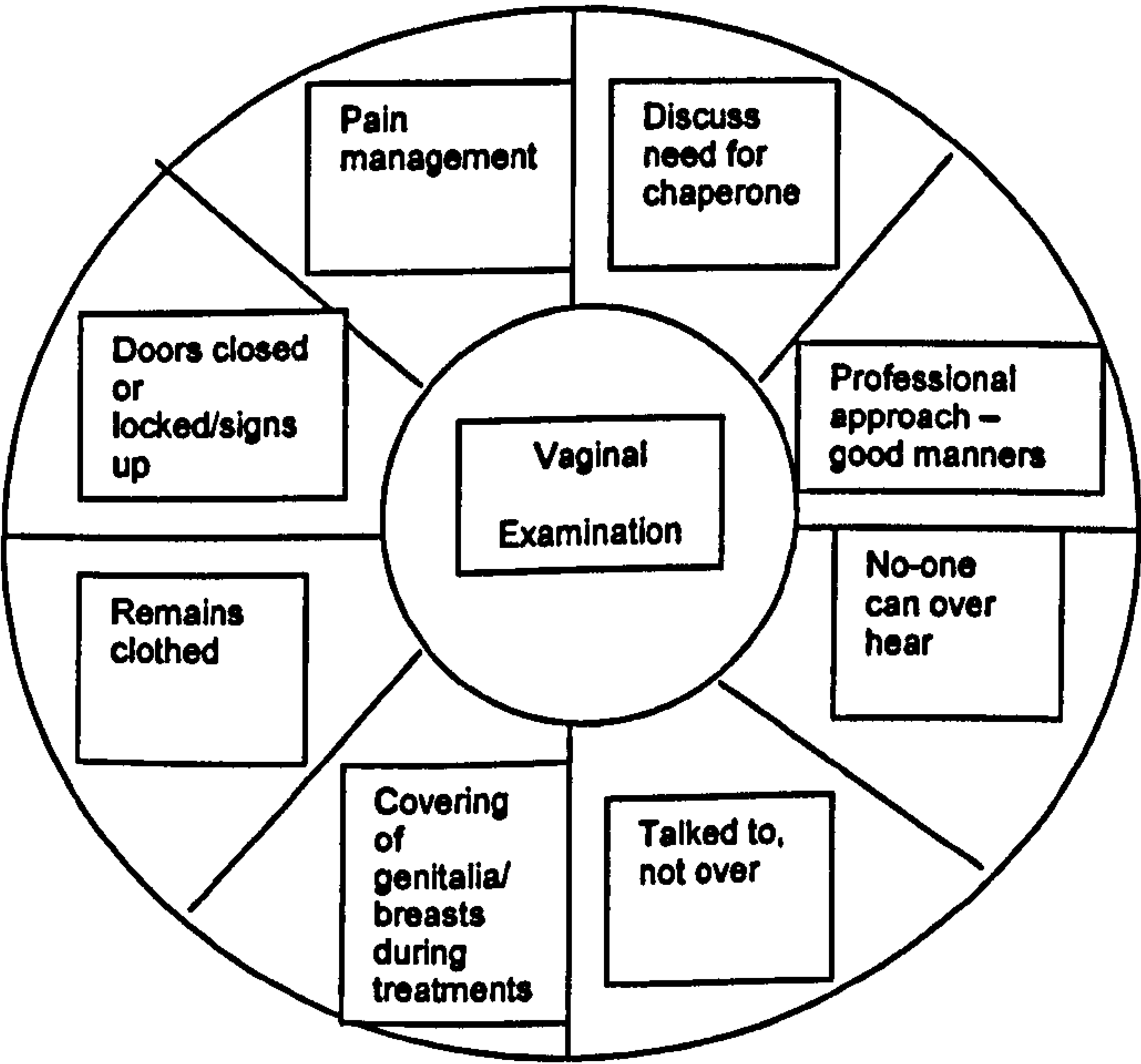


Diagram 8: to show privacy considerations required during a vaginal examination

It could then be argued that if a segment is not addressed by the practitioner then the circle becomes unstable, with the more segments removed from the circle the greater the perceived privacy breach mothers deemed to have occurred. This approach could be utilised in any encounter, for example, abdominal examinations, emergency caesarean sections, ward encounters or breastfeeding. As the use of these diagrams increases a database of potential segments would be created serving to add further depth to the understanding of privacy from the perspective of users of the service. Subsequent research would involve implementation and review of the model into practice to determine its usage and effectiveness in improving privacy for mothers.

Conclusion

This chapter has presented the findings of this research through three sources. Firstly, the differences between the three participants groups as been presented to support the evidence outlined in Chapters 4 – 6. Secondly, the *Essence of Care* benchmark statements were reviewed and considered in light of this research and their application to maternity care environments with recommendations made for improving practice. Lastly, a new tool was presented for incorporation into midwifery practice with the aim of increasing awareness in midwives regarding the privacy needs of mothers and how these can be addressed.

Incorporating three different groups into the research was challenging but resulted in diverse and rich data on each group's interpretation of mothers' privacy. While there were similarities between the groups with regard to issues such as, the need to maintain privacy, there were also distinct differences. Mothers were concerned about losing face in front of others and wanted to remain credible as new mothers both during and after pregnancy. It was important that others were not party to their personal details and had no access to viewing them either during labour or when trying to develop new skills in the postnatal period. Alternatively, midwives transposed their ideals onto mothers using it as a foundation for their care, moving to a privacy management stage, where their aim was to protect mothers from intruders. Students on the other hand played an important role in understanding privacy in maternity care environments, both watching and commenting on mothers' experience, often supplemented by their own personal and practical experience, while offering a commentary on the working practices of midwives. Students introduced new components into the data, discussing such issues as body fluids and 'bedside manners' as important to the study.

The themes emerging from the data included issues relating to the environment, the body, situations, people, viewing and disclosure of information. While some of these are already established as linked to privacy within other subject disciplines, the introduction of them into midwifery environments was new. Within the study the three groups had differing perceptions of privacy within the environment, with mothers wanting a hotel arrangement, midwives seeing it as a place of employment and students as a learning environment. In relation to bodily privacy, mothers related exposure of their bodies to loss of dignity, while midwives expressed a need to assess mothers' wellbeing. Situational privacy highlighted how different situations had the potential to impact on mothers' privacy. Where mothers had a birth without intervention they adopted self introversion to protect their bodily privacy, whereas in situations of compromise they intentionally withdrew to prevent any interference in the work of practitioners delivering their baby. People related privacy mothers described as linked to the manners of other occupants, whereas students linked it to bad 'bedside manners' of staff. Visual privacy, however, showed a difference between mothers' views of being looked at and watched by visitors, other mothers and staff, and midwives' views of needing to observe mothers throughout their stay in hospital. Disclosure of information was also considered by mothers to result from inappropriate discussions, midwives from records held by mothers and students from gossiping, notice-boards, video recordings and inappropriate discussions in a range of settings.

Following review of data the next stage was to develop a means by which to transfer this knowledge into a suitable form for implementation into practice settings. By revisiting the *Essence of Care* (DH 2001a) benchmarks additional recommendations were added and the statements made applicable to midwifery care. The final stage was the design of a usable tool which could be used to implement changes into practice helping to adapt key events, such as vaginal examinations, into individualised episodes where mothers' privacy needs could be identified and addressed. In the final chapter advice on further areas of research and policy recommendations arising from the study, are presented.

Chapter 8: Conclusions and Reflections

Privacy is a subject of concern to a wide and varying audience. When considered in relation to midwifery, which is both a public and private event (public in that people are excited and keen to be involved in acknowledging birth and private in that birth itself should be a private family event), privacy produces challenges both for mothers and for practitioners. The culmination of this project confirms that mothers are concerned about maintaining their privacy both of their body and of their personal information and sometimes found this difficult within the confines of the maternity environment. Mothers' perceptions of privacy are closely related to their need to appear competent as mothers while within a public environment. Throughout their care they are supported by midwives and student midwives, who they acknowledge work within difficult and challenging circumstances. Students offer insight into care within maternity environments offering a unique perspective both as users and soon-to-be midwives as they pass through a state of transition where they draw on both personal and professional experiences. They appear to be outspoken in their views and willing to discuss sensitive topics not addressed by mothers or midwives, suggesting they adopt a role as privacy monitor acting on behalf of mothers. Midwives, by contrast view privacy in relation to their working practices.

This chapter provides a final review of the findings and the research process as a whole. It outlines how the research aims and objectives were addressed, and my reflections on the research process. It also offers recommendations for further research and asserts that recommendations arising from this research will be useful to policy makers. These recommendations supplement those in Chapter 7 which were concerned with improving midwifery practice rather than policy development.

The original aims were to:

- Explore the parameters of privacy in relation to mothers within the maternity environment and assess how they promote, achieve and maintain privacy during and after pregnancy;
- Examine privacy from the perspective of midwives to determine how they perceive, promote, achieve and maintain privacy for mothers in their care.
- Examine privacy from the perspective of student midwives to determine how they perceive, promote, achieve and maintain privacy for mothers while working with midwives.

The majority of research objectives were met with the exception of the design of a privacy model, categorisation of 'non-privacy' events, and the creation of a midwifery related definition for privacy. The research did not simulate the production of model of privacy as such, but instead lent itself to the development a practical tool to assist midwives and students in identifying areas of privacy for individual mothers within individual situations (Chapter 7). The identification of 'non-privacy' events (or a categorisation of privacy breaches) while addressed within the research did not result directly in a categorisation or list of events as originally anticipated. On reflection, such categorisation would not have added depth to the research, nor would it have provided any additional information for implementation into practice. It was more important to explore perceived breaches in the context of the whole story of privacy rather than isolate them. The final objective was the creation of a definition of privacy from the perspective of mothers and midwives. With all the difficulties outlined in producing a definition explored in the literature review chapter (Chapter 2) this was deemed a immense task that warranted further consideration in relation to the concepts outlined within this research. Also the driving force of the research was the need to review privacy in relation to improving practice rather than the provision of an abstract concept such as a definition.

The original questions posed in the initial stages of the research (Chapter 1) were, what is privacy and can it be defined in midwifery practice? Is privacy an issue for practice and if so, is it adequately addressed by staff? How is privacy recognised and promoted in clinical practice? Can its achievement be measured? How do we know what privacy means to individuals particularly women who are pregnant or have just had a baby? Do mothers and midwives have the same perception of what constitutes privacy in maternity care encounters? What criteria would mothers use in deciding if their privacy had been maintained? In periods of admission to hospital is a mother's ability to promote and maintain salient dimensions of privacy decreased? These questions have been addressed throughout the project and presented in Chapter 4 through 6.

This research project is one of the first of its kind relating to privacy in midwifery practice aiming to use a grounded theory methodology. Although the original research design incorporated grounded theory methodology using interviews and observations, modifications to the approach had to be made because of the impact of extraneous factors, which (as Chapter 2 documents) had the potential to close the research early on in the process. The result was data collected from three

main data sources, mothers, midwives and students through focus groups, interviews and participant observations. Grounded theory remained an appropriate methodology through which to study this complex phenomenon because of its ability to explore privacy using the words and actions of participants. If I was asked if I would use grounded theory again for a similar project the answer would be a resounding, yes. While the process of grounded theory originally felt daunting and took a while to master because of the sheer volume of documentation required, once happy with the systematic approach to data collection and analysis, collation of data became easier and more manageable.

In the early stages of the research a tension developed between remaining true to the grounded theory design and meeting the pressures of the LRECs. Meeting with Research Director Leads for the Trusts would have been beneficial and may have helped clarify their expectations of the research before submission. It would also have been useful to have had letters of support from clinical directors on the sites, as those from midwifery managers did not appear to carry sufficient weight to sway the committee. Being able to discuss the design with other researchers, my supervisors and re-reviewing literature relating to grounded theory enabled a review of the project to occur and helped to broaden the design. What the process has shown me was that as a researcher not everything goes according to plan and therefore, you need to be resourceful and adaptable, and even though you may feel your design is suitable selling this to your critics can be a daunting experience.

When it looked as if the project may not proceed, accessing the National Childbirth Trust provided a ready source of mothers. This added a new dimension to the research as these mothers were sited across a range of counties rather than related to one specific maternity service. However, the drawback was that these mothers were mainly white middle class mothers which restricted the focus group findings to this sample group. It would therefore be useful to research the cultural influence on privacy in subsequent studies. On reflection the sample size for mothers and students was appropriate. However, I would have liked to have increased the sample of midwives, but in the current climate of shortages recruitment to the study proved problematic when trying to secure the release of staff from clinical practice. Therefore in any subsequent project this will need to be carefully negotiated and replacement costs may need to be costed into the project.

As the data analysis approach adopted is such an important component of this style of research it was important to use an analytical package that enabled the extensive data and memos to be easily accessible. Atlas.ti turned out to be a good database and once proficient in its use resulted in an easy-to-use facility. It was particularly useful to be able to add memos directly into the package and develop them as the project unfolded. On reflection learning to manage the package while undertaking the project was not necessarily the right approach to adopt, but was inevitable for completion of the project.

Data from the research were presented at two international conferences, two national conferences and four local conferences or seminars (see Appendix 3). These were always stimulating experiences as participants appeared captivated by mothers' stories and resulted in detailed debates on the subject while informing a wider audience of the concepts involved. The feedback obtained, while at times challenging, was useful in validating the analysis and helping to conceptualise ideas. One paper was published during the project and it is hoped that others will now follow.

Recommendations for Future Research

As with any research project further areas for exploration were identified; these are listed below (in no specific order) with a brief rationale for their inclusion:

- *Exploration of the concept of 'loss of face' in relation to new mothers:* mothers within the study related their sense of privacy breach to not wishing to appear incompetent to others within their vicinity. The research has shown it plays a significant role in their perception of privacy and further exploration of the concepts involved would enhance these findings.
- *Privacy attainment in relation to reduced staffing levels:* Midwives within the study outlined problems with maintaining their duty of care in an environment where staffing levels were inadequate and high numbers of visitors obscured their view of mothers. The increased need to observe mothers in these conditions impact on privacy care provision and it is recommended that the implications of reduced numbers of staff and the subsequent increase in surveillance are explored to determine the influence they have on personal privacy.

- *Task competency:* Personal space is known to influence task competency and competency is known to reduce where intrusions are increased (Freedman *et al.* 1971). Task competency was not directly addressed in relation to loss of personal space within this research and the effect this has on mothering skills needs to be considered.
- *The impact of overcrowding in wards:* Increases in numbers of mothers within the maternity environment has led to the perception by participants in this research that wards are spatially challenged. Research needs to explore the type and layout of wards conducive to recuperation and recovery following childbirth. A reduction in public spaces in wards has been shown within this study to result in mothers having to accommodate visitors, physical examinations and seclusion at their bed-space without any evidence as to the influence these may have on privacy.
- *Visiting Numbers:* The numbers of visitors to postnatal wards appears to have significantly increased in recent years according to midwives' reports in this study and when placed in conjunction with a decrease in public space resulted in reports of a sense of overcrowding. Visiting patterns and the bearing visitors have on personal space should therefore be reviewed in relation to timing, numbers of visitors and space available.
- *Labouring in front of others:* Mothers within the study were vocal about their dislike of being in labour in front of others. Research to explore the idea of segregating these mothers from other mothers in wards could be used to assess its impact on the outcome of labour and levels of analgesia required.
- *Essence of Care:* The *Essence of Care* benchmark statements need to be underpinned with context specific research. Therefore all aspects of the benchmark statements have the potential for research projects. Many of these statements are based on practitioners' views of privacy and are not reflective of users, so research to explore and underpin this document in relation to mothers should be considered.
- *Privacy in relation to Minority Ethnic Groups:* The majority of participants within this study were Caucasian mothers. What is not known from the research is the difference in privacy needs

across different cultures and religious groups. For example, do fathers want to be present at the birth of their baby? What are the variations in privacy in relation to bodily exposure, examinations and visual privacy? What is not known is, are there cultural differences in the way in which mothers perceive their privacy, even within this country? Research has already shown cultural differences across countries and it would be useful to know how these differences are interpreted into maternity care in this country (Leineo-Kilpi *et al.* 1999; Leineo-Kilpi *et al.* 2002; Leino-Kilpi *et al.* 2003; Lemonidou *et al.* 2003).

- *The professional right of entry:* Mothers perceived midwives, doctors and other healthcare professionals to have an unquestioned right of entry to their personal space. What needs to be determined is what is incorporated into this right of entry and in which settings does it occur? What practical solutions could be put into place to reduce mothers' and midwives' sense of intrusions? Answers to these questions could then be used to underpin information supplied to mothers on what to expect on admission to hospital.
- *The role of partners in physical examinations:* There was considerable debate within focus groups as to whether partners should remain during physical examinations. While their presence during birth was not questioned, midwives adopted various tactics to remove them during investigations. What we need to know is do mothers want them to remain? If so, why? What role does attendance during these examinations play in partners perceiving mothers to be sexually attractive post birth?
- *The impact of the work environment on privacy of mothers and midwives:* Midwives were acutely aware of the need for wards to be identified as places of work and therefore responsive to their needs as practitioners. A comparison of different working environments and their impact on mothers' perceptions of privacy would help hospital architects to design wards that were responsive to the privacy needs of mothers.
- *The effect of privacy on the recuperation of mothers following birth:* The literature shown in Chapter 2 described how withdrawal and solitude were important to recuperation, and this should be explored further in relation to maternity environments. For example, how does the

loss of withdrawal and solitude affect mothers? Does a reduction in privacy affect their ability to develop mothering skills, initiate breastfeeding or bond with their babies and partners?

- *How does 'policing' of midwives impact on their ability to provide privacy for mothers?* Midwives described how senior midwives and doctors considered themselves to have right of entry to rooms even though cases were progressing normally and did not require intervention. The impact of these intrusions needs to be considered in relation to midwives' ability to offer mothers privacy when their perception of their own autonomy is compromised.
- *Privacy at home compared to hospital:* Two mothers within the study had homebirths and therefore only limited comparisons could be made between home and hospital birth. Exploration of what makes a homebirth more private need to be extrapolated to give some notion of how those principles could be incorporated into hospital practices.
- *The applicability of this research to other healthcare settings:* Although this research was specifically designed to look at privacy within maternity care environments its applicability to other care environments is evident. Research into other clinical areas within healthcare would help to explore the concept further. With the current debates on mixed-sex wards and mix admission wards there is scope to extend the research to other clinical areas to look at the impact of privacy to different conditions or treatments.

While suggestions for further research are important to stimulate exploration of this important topic it is the recommendations from this research which have the potential to underpin local and national policy development.

Policy Recommendations arising from the Research

Chapter 7 outlined recommendations for practice in light of a review of *Essence of Care* (DH 2001a); while it is not my intention to repeat the practice recommendations the following list complements these with a set of recommendations for policy development:

1. Any policy or strategic document relating to privacy must base its foundation on the views and perceptions of users of the service, without whom incorrect provision of privacy care can result.

2. A review of midwifery related documents which provide evidence for standards of midwifery practice, such as NICE guidelines and RCM Brown Study Series (NICE 2001; RCM 2001; NICE 2003), should be undertaken to ensure that privacy enhancing strategies are included. This will ensure that situations, where mothers perceive their privacy to be compromised, reduce or cease; for example positive segregation of mothers in labour from non-labouring mothers.
3. Continuing professional education and pre-registration education should highlight the importance of good bedside manners in the promotion of mothers' sense of privacy. Being disrespectful or patronising to mothers is not acceptable and should be eliminated within all levels of NHS staff. The role of good midwifery skills, such as, trust, respect, good communication and advocacy while already evident in varying degrees within midwifery practice, should be enhanced across other healthcare professionals.
4. The role of technology in reducing privacy for mothers should be acknowledged and steps taken to ensure communication with mothers (or patients) is not reduced. Where technology was incorporated into mothers' care, interactions with mothers declined as interactions with technology increased.
5. Guidance on good privacy practice during operative procedures should be developed. The notion of discussions taking place across or around mothers should cease and the number of staff in theatres kept to a minimum. Leaving mothers (or patients) exposed following procedures is unacceptable and practice guidance should be given.
6. Policy makers should consider enhancing the role of the midwife in relation to ensuring that women remain, and are monitored, at home in the early stages of labour and are transferred home as soon as possible in the postnatal period so as to reduce overcrowding. Moving mothers into hospital early enhances overcrowding, overhearing of mothers in pain and the possibility of mothers being viewed by others.
7. Guidance should be provided at Trust level on the management of institutional gossiping. While it is difficult to eliminate, clear guidance on acceptable boundaries should be given. This guidance should also include the management of informational disclosure relating to conversations at nurses' stations, ward rounds and handovers.
8. Policy makers and building designers should acknowledge the importance of personal space both for mothers and their partners when designing or refurbishing maternity hospitals. Adequate provision should be made for partners to acquire personal space in

places like delivery suites. Bedroom space should remain as personal space for mothers and public spaces made available for entertaining guests. Wards should appear more 'homely', should ensure that beds are not directly facing each other and where a move to single room accommodation is not possible, the number of beds contained within each space are reduced to no more than two. Designers should consider sitting-room style accommodation with café facilities where mothers and visitors could sit during visiting.

This research commenced with questions relating to whether privacy was an issue for mothers and midwives within maternity care environments and has confirmed the importance of privacy to mothers, midwives and student midwives. It has enabled a better understanding of the concepts involved in privacy and how they are applicable to midwifery practice. While it has demonstrated differences between participants this important area has identified new avenues for privacy which could be explored further in other healthcare settings.

References:

- Agne, P (1994) 'Surveillance and capture: two models of privacy', *Information Society*, **10** (2) pp 101 - 127.
- Ah-Fat, B (2004) *Essence of Care Eureka: Privacy and Dignity Benchmark - Velcro to bed curtains*, London, NHS Modernisation Agency Clinical Governance Support Team
- Akdeniz, Y (2002) 'Anonymity, Democracy, and Cyberspace', *Social Research*, **69** (1) pp 223 - 238.
- Alder, P and Alder, P (1998) Observational Techniques, In: N Denzin and Y Lincoln (ed), *Collecting and Interpreting Qualitative Materials*, London, Sage Publications, 79 - 109.
- Alderman, E and Kennedy, C (1997) *The Right to Privacy*, New York, Vintage Books.
- Alexis, A (1986) 'Body searches and the right to privacy', *Journal of Psychosocial Nursing and Mental Health*, **24** (11) pp 21 - 25.
- Allekian, C (1973) 'Intrusions of territory and personal space', *Nursing Research*, **22** (3) pp 236 - 241.
- Allen, A (2001a) 'Is privacy now possible? A brief history of an obsession', *Social Research*, **68** (1) pp 301 - 305.
- Altman, I (1975) *The Environment and Social Behaviour*, California, Brooks/Cole Publishing Company.
- Applegate, M and Morse, J (1994) 'Personal privacy and interactional patterns in a nursing home', *Journal of Ageing Studies*, **8** (4) pp 413 - 434.
- Arendt, H (1958) *The Human Condition*, London, The University of Chicago Press.
- Arsanian, C (1997) 'Reviewing the literature', *Orthopaedic Nursing*, **16** (2) pp.
- Atkinson, P (1997) 'Narrative turn or blind alley?' *Qualitative Health Research*, **7** pp 325-344.
- Atkinson, P and Hammersley, M (1998) Ethnography and Participant Observation, In: N Denzin and Y Lincoln (ed), *Strategies of Qualitative Inquiry*, London, Sage Publications, 110 - 136.
- Audit Commission (2000) *Getting better all the time: making benchmarking work*, London, Audit Commission.
- Aveyard, H (2002) 'The requirement for informed consent prior to nursing care procedures', *Journal of Advanced Nursing*, **37** (3) pp 243 - 249.
- Back, E and Wikbald, K (1998) 'Privacy in hospital', *Journal of Advanced Nursing*, **27** (5) pp 940 - 945.
- Badzek, L, Mitchell, K, Marra, S and Bower, M (1998) Administrative ethics and confidentiality privacy issues, *Online Journal of Issues in Nursing*.
- Bailey, J (2002) 'From Public to Private: the development of the concept of 'private' ', *Social Research*, **69** (1) pp 15 - 34.
- Banisar, D (2000) *Privacy & Human Rights: an international survey of privacy laws and developments*, USA, electronic and Privacy Information Center and Privacy International.
- Barber, T (2001) 'RESPECT Protecting the privacy and dignity of patients is a long-standing staple of nursing', *Nursing Times*, **97** (47) pp 23 - 25.
- Barbour, R (2001) 'Checklists for improving rigour in qualitative research: a case of the tail wagging the dog?' *British Medical Journal*, **322** pp 1115-1117.

- Barclay, L, Everitt, L, Rogan, F, Schmied, V and Wyllie, A (1997) 'Becoming a mother - An analysis of women's experience of early motherhood', *Journal of Advanced Nursing*, **25** (4) pp 719 - 728.
- Barrett, R (1995) 'Elephant people: the phenomena of social withdrawal and self-imposed isolation of people dying with AIDS,' *Aids Patient Care*, **9** (5) pp 240-244.
- Barron, A (1990) 'Privacy: The Right to Personal Space', *Nursing Times*, **86** (27) pp 28 - 32.
- Barry, R (2001) 'Atlas/ti and NUDIST: a comparative review of two leading qualitative data analysis packages', *Cultural Anthropology Methods*, **10** (3) pp 41 - 47.
- Basford, P and Downie, C (1990) 'How to. review an article', *Nursing Times*, **86** (40) pp 3-9.
- Bates, A (1964) 'Privacy - A useful concept?' *Social Forces*, **42** pp 432.
- Bayne-Powell, R (1937) *Eighteenth-Century London Life*, London, J Murray.
- Beauchamp, T and Childress, J (1989) *Principles of Biomedical Ethics*, Oxford, Oxford University Press.
- Beilin, Y, Leibowitz, A and Bernstein, H (1999) 'Controversies of labour - epidural analgesia', *Anaesthesia and Analgesia*, **89** (4) pp 969 - 980.
- Bell, F J (1998) 'Reviewing the literature: a student's perspective', *Journal of Child Health Care*, **2** (3) pp 122-127.
- Benhabib, S (1993) 'Feminist theory and Hannah Arendt's concept of public space', *History of the Human Sciences*, **6** (2) pp 97 - 114.
- Benn, S (1971) Privacy, Freedom and Respect for Persons, In: J Pennock and J Chapman (ed), *Privacy*, New York, Atherton, 1 - 26.
- Benner, P (1984) *From Novice to Expert: excellence and power in clinical nursing practice*, California, Addison-Wesley Publishing Company.
- Bennett, C (1991) 'Computers, personal data and theories of technology: comparative approaches to privacy protection in the 1990s', *Science, Technology and Human Values*, **16** (1) pp 51 - 69.
- Berg, J, Appelbaum, P, Lidz, C and Parker, L (2001) *Informed consent: Legal theory and Clinical Practice 2nd Edition*, USA, Oxford University Press Inc.
- Bird, D (2003) 'Discovering the literature of nursing: a guide for beginners', *Nurse Researcher*, **11** (1) pp 56 - 70.
- Bloustein, E (1984) Privacy as an aspect of human dignity, In: F Schoeman (ed), *Philosophical Dimensions of Privacy: an anthology*, New York, Cambridge Press, 156 - 197.
- Bloustein, E (2003) *Individual and Group Privacy*, London, Transaction Publishers.
- Bolger, T (1985) 'Avoiding gossip on the bus', *Nursing Mirror*, **160** (10) pp 15.
- Boling, P (1996) *Privacy and the Politics of Intimate Life*, London, Cornell University Press.
- Bolton, S (2006) Gynaecology nursing: dirty work, women's work, In: M Kirkham (ed), *Exploring the Dirty Side of Women's Health*, London, Routledge, 215-226.
- Boone, C (1983) 'Privacy and Community', *social Theory and Practice*, **9** (1) pp 1 - 30.
- Brooks, F and Lomax, H (2000) *Labouring bodies: mothers and maternity policy*, In Ellis K Harley D (eds.) *Social Policy and the Body: transitions in corporeal disease*, London, Macmillan.
- Burden, B (1994) Privacy in the Ward Environment, *Department of Sociology*, Surrey, University of Surrey. **Master of Science**.
- Burden, B (1998) 'Privacy or help? The use of curtain positioning strategies within the maternity ward environment as a means of achieving and maintaining privacy, or as a form of signalling to

- peers and professionals in an attempt to seek information and support', *Journal of Advanced Nursing*, **27** pp 15 - 23.
- Burden, B (2001) 'Writing a review of the literature: a practical guide', *British journal of Midwifery*, **9** (8) pp 498 - 501.
- Burden, B and Wenman, H (2004) Children Act and Social Services, In: C Henderson and S Macdonald (ed), *Mayes' Midwifery: a textbook for midwives 13th Edition*, London, Bailliere Tindall, 1050 - 1068.
- Burgess, L (1994) 'Mixed sex wards - the NT survey results', *Nursing Times*, **90** (31) pp 35 - 38.
- Burgess, R (1984) *In the Field: an introduction to field research*, London, Routledge.
- Burke, K (1945) *A Grammar of Motives*, New York, Prentice Hall Inc.
- Chadderton, H (1996) 'Literature review: an essential skill for nurse managers', *Journal of Nursing Management*, **4** (5) pp 255-256.
- Charmaz, K (1994b) The Grounded Theory Method: an explication and interpretation, In: B Glaser (ed), *More Grounded Theory Methodology: a reader*, Mill Valley, Sociology Press, 95 - 115.
- Charmaz, K (2006) *Constructing Grounded Theory: a practical guide through qualitative analysis*, London, Sage.
- Cheal, D (1991) *Family and the State of Theory*, London, Harvester Wheatsheaf.
- Cheek, J (1996) 'Taking a view: Qualitative research as representation', *Qualitative Health Research*, **6** pp 492-505.
- Chenitz, W and Swanson, J (1986) *From Practice to Grounded Theory: qualitative research in nursing*, Wokingham, Addison Wesley.
- Chilton, L and Berger, J (1999) 'Privacy protection of health information: patient rights and pediatrician responsibilities', *Pediatrics*, **104** (4) pp 973 - 978.
- Clark, E (2004) 'Quality of life: a basis for clinical decision-making in community psychiatric care', *Journal of Psychiatric and Mental Health Nursing*, **11** pp 725 - 730.
- Coetzee, M (2004) 'Learning to nurse children: towards a model for nursing students', *Journal of Advanced Nursing*, **47** (6) pp 639 - 648.
- Coffey, A (1999) *The Ethnographic Self: Fieldwork and the Representation of Identity*, London, Sage.
- Cohen, J (2001) 'The Necessity of Privacy', *Social Research*, **68** (1) pp 318 - 326.
- Cole, A (1995) 'No mixed sex, please', *Nursing Times*, **21** (29) pp 44 - 47.
- Coontz, S (1988) *The Social Origins of Private Life*, London, Verso.
- Cooper, J (2003) *Privacy: European Human Rights Law Review Special Issue*, London, Sweet and Maxwell Limited.
- Corbin, J and Strauss, A (1984) 'Collaboration: couples working together to manage chronic illness', *Image*, **16** pp 109 - 115.
- Curtin, L (1986) 'Guest relations and private obligations', *Nursing Management*, **17** (5) pp 40 - 42.
- Curtin, L (1992) 'Privacy: Belonging to One's Self', *Nursing Management*, **23** (4) pp 7 - 8.
- Curtin, L (1993) 'Patient privacy in a public institution', *Nurse-Manager*, **24** (6) pp 26 - 27.
- Dahlen, R, Brundage, C A and Roth, C B (1987) 'Guidelines for doing a computerized literature search', *Nurse Education*, **12** (2) pp 17-21.
- Davidson, L (1990) 'A Room of their own?' *Nursing Times*, **86** (27) pp 32 - 33.

- Decew, J (1997) *In Pursuit of Privacy: Law, Ethics, and the Rise of Technology*, London, Cornell University Press.
- Deshefy-Longhi, T, Dixon, J, Olsen, D and Grey, M (2004) 'Privacy and confidentiality issues in primary care: views of advanced practice nurses and their patients', *Nursing Ethics*, 11 (4) pp 378 - 393.
- Desor, J (1972) 'Towards a psychological theory of crowding', *Journal of Personality and Social Psychology*, 21 pp 79 - 83.
- Dey, I (1993) *Qualitative Data Analysis: a user friendly guide for social scientists*, London, Routledge.
- Dey, I (1999) *Grounding Grounded Theory: Guidelines for Qualitative Inquiry*, Edinburgh, Academic Press.
- DH (1993) *Changing Childbirth: Report of the Expert Maternity Group*, London, The Stationery Office Books
- DH (1997a) *The new NHS: modern, dependable*, London, The Stationery Office.
- DH (1997b) *The Caldicott Committee: Report on the review of patient-identifiable information*, London, Department of Health.
- DH (1998a) *A First Class Service: quality in the new NHS*, London, Department of Health.
- DH (1998b) *Promoting clinical effectiveness: a framework for action in and through the NHS*, London, Department of Health.
- DH (1998c) *Modernising Mental Health Services, safe, sound and supportive*, London, Department of Health
- DH (1999) *Making a Difference: strengthening the nursing, midwifery and health visiting contribution to health and healthcare*, London, Department of Health.
- DH (2000) *The NHS Plan: a plan for investment, a plan for reform*, London, The Stationery Office.
- DH (2001a) *Essence of Care*, London, Department of Health.
- DH (2001b) *Consultation document part 2: Access Controls for the NHS Strategic Tracing Service*, London, Department of Health.
- DH (2001c) *Consultation Paper - Caldicott Guardians*, London, Department of Health.
- DH (2001d) *National Service Framework for Older People*, London, Department of Health.
- DH (2003) *Confidentiality: NHS Code of Practice*, London, DH Publications.
- DH (2005) *Elimination of Mixed-Sex accommodation*, London, Department of Health.
- DH (2006) *Improving the patient experience: celebrating achievement: Enhancing the healing environment programme*, London, Department of Health.
- Dimond, B (2003) 'Step 49: The right to respect for privacy', *British Journal of Midwifery*, 11 (1) pp 22.
- Donovan, J (1995) 'The process of analysis during a grounded theory study of men during their partners' pregnancies', *Journal of Advanced Nursing*, 21 pp 708 - 715.
- Elshtain, J (1982) *Public Man, Private Woman: Women in Social and Political Thought*, London, Blackwell Publishers.
- Emerson, J (1970) Behaviour in private places: sustaining definitions of reality in gynaecological examinations, In: H Dreitzel (ed), *Recent Sociology*, New York, Macmillan, p73 - 100.

- Emerson, R, Fretz, R and Shaw, L (2001) Participant observation and fieldnotes, In: P Atkinson (ed), *Handbook of Ethnography*, London, Sage.
- Etzioni, A (1999) *The Limits of Privacy*, New York, Basic Books.
- Evans, G, Rhee, E, Forbes, C, Mata Allen, K and Lepore, S (2000) 'The meaning and efficacy of social withdrawal as a strategy for coping with chronic residential crowding', *Journal of Environmental Psychology*, 20 (4) pp 335 - 342.
- Ezeh, P (2003) 'Integration and its challenges in participative observation', *Qualitative Research*, 3 (2) pp 199 - 205.
- Fahey, T (1995) 'Privacy and the family: conceptual and empirical reflections', *Sociology*, 29 (4) pp 687 - 702.
- Feinberg, J (1983) 'Autonomy, Sovereignty, and Privacy: moral ideals in the constitution?' *Notre Dame Law Review*, 58 pp 445 - 492.
- Felipe, R and Sommer, R (1966) 'Invasions of personal space', *Social Problems*, 14 pp 206 - 214.
- Ferguson, G and Wadham, J (2003) Privacy and Surveillance: A Review of the Regulation of the Investigatory Powers Act 2000, In: J Cooper (ed), *Privacy: European Human Rights Law Review Special Issue*, London, Sweet and Maxwell Limited, 101 - 108.
- Fielding, N and Lee, R, Eds. (1991) *Using Computers in Qualitative Analysis*, Berkeley, Sage Publications.
- Firestone, S (1979) *The Dialectic of Sex: the case for feminist revolution*, London, The Women's Press Limited.
- Fisher, J and Bryne, D (1975) 'Too close for comfort: sex differences in response to invasions of personal space', *Journal of Personality and Social Psychology*, 32 pp 15 - 21.
- Fontana, A and Frey, J (1998) Interviewing: the art of science, In: N Denzin and Y Lincoln (ed), *Collecting and Interpreting Qualitative Materials*, London, Sage Publications, 47 - 78.
- Foucault, M (1973) *The Birth of the Clinic*, London, Routledge.
- Frankel, M (1983) The laying on of hands: aspects of the organisation of gaze, touch and talk in a medical encounter, In: S Fisher and A Todd (ed), *The Social Organization of Doctor-Patient Communication*, Washington, Center for Applied Linguistics, p19 - 55.
- Fraser, J (1987) 'The Community, the Private and the Individual', *The Sociological Review*, 35 pp 795 - 818.
- Fraser, N (1994) Rethinking the Public Sphere, In: H Giroux and P McLaren (ed), *Between Borders: Pedagogy and the Politics of Cultural Studies*, London, Routledge.
- Freedman, J, Klevansky, S and Ehrlich, P (1971) 'The effect of crowding on human task performance', *Journal of Applied Social Psychology*, 1 pp 7 - 26.
- Freedman, J, Levy, A, Buchanan, R and Price, J (1972) 'Crowding and human aggressiveness', *Journal of Experimental Social Psychology*, 8 pp 528 - 548.
- Fried, C (1970) *An anatomy of values*, Cambridge, Mass.
- Fried, C (1984) Privacy, In: F Schoeman (ed), *Philosophical Dimensions of Privacy: an anthology*, Cambridge, Cambridge University Press.
- Gallagher, T (2001) 'Patient dignity equals privacy', *Nursing Times*, 97 (48) pp 21.
- Gardener, K (1997) *Songs at the River's Edge*, London, Pluto Press.

- Garmanikow, E, Morgan, D, Purvis, J and Taylorson, D (1983) *The Public and the Private*, London, Heinemann.
- Garrow, D (2001) 'Privacy and the American Constitution', *Social Research*, 68 (1) pp 55 - 82.
- Gavison, R (1984) Privacy and the limits of the law, In: F Schoeman (ed), *Philosophical Dimensions of Privacy: an anthology*, Cambridge, Cambridge University Press.
- Gavison, R (1992) 'Feminism and the Public/Private Distinction', *Stanford Law Review*, 45 pp 1 - 45.
- Gerstein, R (1984) Intimacy and Privacy, In: F Schoeman (ed), *Philosophical Dimensions of Privacy: an anthology*, Cambridge, Cambridge University Press.
- Gibbs, A (1997) *Focus Groups*, Surrey, University of Surrey Accessed online at <http://www.soc.surrey.ac.uk/sru>.
- Gibson, F and Bamford, O (2001) 'Focus group interviews to examine the role and development of the clinical nurse specialist', *Journal of Nursing Management*, 9 pp 331 - 342.
- Glaser, B (1992) *Emergence vs forcing: Basics of grounded theory analysis*, Mill Valley, Sociology Press.
- Glaser, B (1994a) The Constant Comparative Method of Qualitative Analysis, In: B Glaser (ed), *More Grounded Theory Methodology: a reader*, Mill Valley, USA, Sociology Press, 182 - 196.
- Glaser, B (1994b) Generating Formal Theory, In: B Glaser (ed), *More Grounded Theory Methodology: a reader*, Mill Valley, USA, Sociology Press, 268 - 285.
- Glaser, B (1994c) The Grounded Theoretical Elaboration of Quantitative Data, In: B Glaser (ed), *More Grounded Theory Methodology: a reader*, Mill Valley, USA, Sociology Press, 197 - 232.
- Glaser, B (1994d) *More Grounded Theory Methodology: a reader*, Mill Valley, USA, Sociology Press.
- Glaser, B (1994e) Organizational Careers: A Formal Theory, In: B Glaser (ed), *More Grounded Theory Methodology: a reader*, Mill Valley, USA, Sociology Press, 286 - 322.
- Glaser, B (1994f) The Practical Use of Awareness Theory, In: B Glaser (ed), *More Grounded Theory Methodology: a reader*, Mill Valley, USA, Sociology Press, 146 - 158.
- Glaser, B (1994g) Retreading Research Materials: The use of secondary analysis by the independent researcher, In: B Glaser (ed), *More Grounded Theory Methodology: a reader*, Mill Valley, USA, Sociology Press, 246 - 259.
- Glaser, B (1994h) Secondary Analysis and Grounded Theory: the use of knowledge from research elsewhere, In: B Glaser (ed), *More Grounded Theory Methodology: a reader*, Mill Valley, USA, Sociology Press, 260 - 267.
- Glaser, B and Strauss, A (1968) *Time for Dying*, Chicago, Aldine.
- Glaser, B and Strauss, A (1975) *Chronic illness and the quality of life*, St Louis, C V Mosby.
- Glaser, B and Strauss, A (1994a) Case Histories and Case Studies, In: B Glaser (ed), *More Grounded Theory Methodology: a reader*, Mill Valley, USA, Sociology Press, 233 - 245.
- Glaser, B and Strauss, A (1994b) Time, Structural Process, and Status Passage, In: B Glaser (ed), *More Grounded Theory Methodology: a reader*, Mill Valley, USA, Sociology Press, 377 - 388.
- Glaser, B and Strauss, a L (1965) *Awareness of Dying*, Chicago, Aldine Publishing Co.
- Glaser, B G and Strauss, A (1967) *The Discovery of Grounded Theory: strategies for qualitative research*, New York, Aldine de Gruyter.

- Glen, S and Jownally, S (1995) 'Privacy: a key nursing concept', *British Journal of Nursing*, 4 (2) pp 69 - 72.
- Goffman, E (1959) *The Presentation of Self in Everyday Life*, London, Penguin Books.
- Goffman, E (1961) *Asylums: Essays on the social situation of mental patients and other inmates*, London, Penguin Books.
- Goffman, E (1963) *Behavior in Public Places*, New York, The Free Press.
- Goffman, E (1967) *Interaction Ritual: Essays on face-to-face behavior*, New York, Pantheon Books.
- Goldman, A (1962) 'The group depth interview', *Journal of Marketing*, 26 pp 61- 68.
- Graham, H and Oakley, A (1981) Competing Ideologies of Reproduction: medical and maternal perspectives on pregnancy, In: H Roberts (ed), *Women, Health and Reproduction*, London, Routledge and Kegan Paul.
- Gramaccini, N (1998) *Die Freuden des privaten Lebens: das interieur im historischen wandel*, cited in Rossler B 2005 *The Value of Privacy*, Cambridge, Polity.
- Graneheim, U, Norberg, A and Jansson, L (2001) 'Interaction relating to privacy, identity, autonomy and security: an observational study focusing on a woman with dementia and 'behavioural disturbances', and on her care providers', *Journal of Advanced Nursing*, 36 (2) pp 256 - 265.
- Great Britain (1998a) *Data Protection Act*, London, The Stationery Office.
- Great Britain (1998b) *The Human Rights Act*, London, The Stationery Office.
- Gross, H (1971) Privacy and Autonomy, In: J Pennock and J Chapman (ed), *Privacy*, New York, Atherton, 169 - 181.
- Gubruim, J (1975) *Living and Dying at Murray Manor*, New York, St Martin's Press.
- Halmos, P (1953) *Solitude and Privacy: a study of social isolation, its causes and therapy*, New York, Philosophical Library Inc.
- Hansen, K (1987) 'Feminist Conceptions of Public and Private: a Critical Analysis', *Berkeley Journal of Sociology*, 32 pp 105 - 128.
- Hart, C (1998) *Doing a Literature Review*, London, Sage Publications.
- Heath, C (1986) *Body Movement and Speech in Medical Interaction*, Cambridge, Cambridge University Press.
- Heath, C (2004) Analysing face-to-face interaction: video, the visual and material, In: D Silverman (ed), *Qualitative Research: Theory, Method and Practice 2nd Edition*, London, Sage Publications, 266 - 282.
- Hek, G (1994) 'Searching the Literature', *Journal of Community Nursing*, 8 (8) pp 24.
- Henderson, M (1975) 'Acquiring Privacy in Public', *Urban Life and Culture*, 3 (4) pp 446 - 455.
- Heneghan, A, Mercer, M and Deleone, N (2004) 'Will mothers discuss parenting stress and depressive symptoms with their child's pediatrician?' *Pediatrics*, 113 (3) pp 460 - 467.
- Henslin, J and Biggs, M (1995) Behaviour in public spaces: the sociology of the vaginal examination, In: J Henslin (ed), *Down to earth sociology: introductory readings*, New York, Free Press.
- Holmes, S (1996) 'Systematic search offers a sound evidence base. literature review', *Nursing Times*, 92 (4) pp 37-39.
- Hoppe, M and Wells, E (1995) 'Using focus groups to discuss sensitive topics with children', *Evaluation Review*, 19 (1) pp 102 - 115.

- Hudson, A (2003) Privacy: a right by any other name, In: J Cooper (ed), *Privacy: European Human Rights Law Review Special Issue*, London, Sweet and Maxwell Limited, 73 - 85.
- Hunt, S and Symonds, A (1995) *The Social Meaning of Midwifery*, Basingstoke, Macmillan.
- Hutton, A (2002) 'The private adolescent: privacy needs of adolescents in hospitals', *Journal of Pediatric Nursing*, 17 (1) pp 67 - 72.
- Imray, L and Middleton, L (1983) Public and the Private: Marking the Boundaries, In: E Gamarnikow, D Morgan, J Purvis and G Taylorson (ed), *The Public and the Private*, London, Heinemann, 12 - 27.
- Inness, J C (1992) *Privacy, Intimacy and Isolation*, Oxford, Oxford University Press.
- Introna, L (1997) 'Privacy and the computer: why we need privacy in the information society', *Metaphilosophy*, 28 (3) pp 259 - 275.
- Jacelon, C (2003) 'The dignity of elders in an acute care hospital', *Qualitative Health Research*, 13 (4) pp 543 - 556.
- Jacelon, C, Connelly, T, Brown, R, Proulx, K and Vo, T (2004) 'A concept analysis of dignity for older adults', *Journal of Advanced Nursing*, 48 (1) pp 76 - 83.
- Jain, U (1987) 'Effects of population density and resources on the feeling of crowding and personal space', *Journal of Social Psychology*, 127 pp 331 - 338.
- Janssen, P, Klein, M, Harris, S, Soolsma, J and Seymour, L (2000) 'Single room maternity care and client satisfaction', *Birth*, 27 (4) pp 235 - 243.
- Johnson, M (1992) 'A silent conspiracy? Some ethical issues of participant observation in nursing research', *International Journal of Nursing Studies*, 29 (2) pp 213-223.
- Johnson, R (1989) The impact of the hospital environment on early maternal mood states, San Francisco, University of California. D.N.S.: 245.
- Jones, M (1974) *Privacy*, London, David & Charles.
- Jourard, S (1966) 'An exploratory study of body accessibility', *British Journal of Social and Clinical Psychology*, 5 pp 221-231.
- Jourard, S (1967) 'Out of touch: the body taboo', *New Society*, 10 (267) pp 660-662.
- Jourard, S and Rubin, J (1968) 'Self-disclosure and touching: a study of two modes of interpersonal encounter and their interaction', *Journal of Humanistic Psychology*, 5 pp 39-48.
- Kateb, G (2001) 'On being watched and known', *Social Research*, 68 (1) pp 269 - 298.
- Kaya, N and Erkip, F (1999) 'Invasion of personal space under the condition of short term crowding: a case study on an automatic teller machine', *Journal of Environmental Psychology*, 19 pp 183 - 189.
- Keats, D (2000) *Interviewing: a practical guide for students and professionals*, Buckingham, Open University Press.
- Kelly, K (2003) *Domestic Violence and the Politics of Privacy*, London, Cornell University Press.
- Kelvin, P (1973) 'A social psychological examination of privacy', *British Journal of Social and Clinical Psychology*, 12 pp 248 - 261.
- Kerr, J (1985) 'Space use, privacy and territoriality', *West Journal of Nursing Research*, 7 (2) pp 199 - 219.
- Kirk-Smith, M (1996) 'Finding, reading and documenting literature', *Nursing Times*, 95 (15) pp 34 - 35.

- Kirkham, M (1989) Midwives and information giving during labour, In: S Robinson and A Thomson (ed), *Midwives, Research and Childbirth Volume 1*, London, Chapman and Hall.
- Kitzinger, J (1994) 'The methodology of focus groups: the importance of interaction between research participants', *Sociology of Health and Illness*, **16** (1) pp 103 - 121.
- Kitzinger, J (1995) 'Introducing group interviewing', *British Medical Journal*, **311** (7000) pp 299 - 303.
- Kitzinger, J and Barbour, R (1999) Introduction: the challenge and promise of focus groups, In: R Barbour and J Kitzinger (ed), *Developing focus group research, politics, theory and practice*, London, Sage, 1 - 20.
- Klein, L (1997) 'Computers, surveillance and privacy', *Social Science Computer Review*, **15** (14) pp 456 - 458.
- Knepfer, G and Johns, C (1989) *Nursing for Life*, London, Pan Books.
- Kovacs, A (2002) 'Public Identity in Defining the Boundaries of Public and Private: the example of latent Anti-Semitism', *Social Research*, **69** (1) pp 179 - 194.
- Krueger, R (1995) 'The future of focus groups', *Qualitative Health Research*, **5** (4) pp 524 - 531.
- Langlands, A (1997) *The Patients Charter: privacy and dignity and the provision of single sex hospital accommodation*, London, Department of Health NHS Executive.
- Lawler, J (1991) *Behind the Screens: Nursing Somology and the Problem of the Body*, London, Churchill Livingstone.
- Lawson, B (2004) *Essence of Care Eureka: Privacy and Dignity Benchmark*, London, NHS Modernisation Agency Clinical Governance Support Team
- Lazarus, J (1969) The Inner Circle Strategy: Identifying Crucial Problems, In: J Krumboltz and C Thoresen (ed), *Behavioural Counselling: Cases and Techniques*, New York, Holt Publishing, 19 - 24.
- Lederer, S, Hong, J, Dey, A and Landay, J (2004) 'Personal privacy through understanding and action: five pitfalls for designers', *Personal and Ubiquitous Computing*, **8** (6) pp 440 - 454.
- Leineo-Kilpi, H, Valimaki, M, Dassen, T, Gasull, M, Lemonidou, C, Scott, P A and Arndt, M (1999) 'Patients' autonomy and privacy in nursing interventions', *Nursing Ethics*, **6** (4) pp 337 - 338.
- Leineo-Kilpi, H, Valimaki, M, Dassen, T, Gasull, M, Lemonidou, C, Scott, P A, Arndt, M and Kaljonen, A (2002) 'Maintaining privacy on postnatal wards: a study in five European countries', *Journal of Advanced Nursing*, **37** (2) pp 145 - 154.
- Leino-Kilpi, H, Valimaki, M, Dassen, T, Gasull, M, Lemonidou, C, Schopp, A, Scott, P, Arndt, M and Kaljonen, A (2003) 'Perceptions of autonomy, privacy and informed consent in the care of elderly people in five European countries: comparison and implications for the future', *Nursing Ethics*, **10** (1) pp 58 - 66.
- Lemonidou, C, Leino-Kilpi, H, Valimaki, M, Dassen, T, Gasull, M, Scott, P, Merkouris, A, Arndt, M and Kaljonen, A (2003) 'Privacy in surgical nursing care: a comparative study of patients' and nurses' perceptions', *Advanced Perioperative Care*, **1** (4) pp 113 - 122.
- Lemonidou, C, Merkouris, A, Leino-Kilpi, H, Valimaki, M, Dassen, T, Gasull, M, Scott, P, Tafas, C and Arndt, M (2003) 'A comparison of surgical patients' and nurses' perceptions of patients' autonomy, privacy and informed consent in nursing interventions', *Clinical Effectiveness in Nursing*, **7** (2) pp 73 - 83.

- Lessig, L (2002) 'Privacy as Property', *Social Research*, 69 (1) pp 247 - 269.
- Levinas, E (1969) *Totality and Infinity: an essay on Exteriority*, Pittsburgh, A Lingis.
- Lindsey, R (1984) 'Informed consent and deception in psychotherapy research - an ethical analysis', *Counselling Psychologist*, 12 pp 79 - 86.
- Lofland, J and Lofland, L (1984) *Analyzing Social Settings: a guide to qualitative observation and analysis*, California, Wadsworth Publishing Company.
- Lopata, H (1993) 'The Interweave of Public and Private: Women's Challenge to American Society', *Journal of Marriage and the Family*, 55 pp 176 - 190.
- Lott, J W (1995) 'Get the most out of a literature search using a computerized system', *Neonatal Network*, 14 (4) pp.
- Loy, J (1999) 'How to. do a literature search', *Midirs Midwifery Digest*, 9 (4) pp.
- Macinnes, D (1999) *Ethical issues in clinical research Nursing Times Clinical Monographs No 14*, London, Nursing Times Books.
- Mackinnon, C (1983) 'Feminism, Marxism, and the State: towards a feminist jurisprudence', *Signs*, 8 pp 639.
- Madgwick, D and Smythe, T (1974) *The Invasion of Privacy*, London, Pitman Publishing.
- Madriz, E (1998) 'Using focus groups with lower socioeconomic status Latina women', *Qualitative Enquiry*, 4 (1) pp 114 - 129.
- Magnusson, A and Lutzen, K (1999) 'Intrusion into patient privacy: a moral concern in the home care of persons with chronic mental illness', *Nursing Ethics*, 6 (5) pp 399 - 410.
- Magnusson, A, Severinsson, E and Lutzen, K (2002) 'Nurses' views on situations related to privacy in providing home care for persons with long-term mental illness: an explanatory study', *Issues in Mental Health Nursing*, 23 (1) pp 61 - 75.
- Majtenyi, L (2002) 'Ensuring Data Protection in East-Central Europe', *Social Research*, 69 (1) pp 151 - 178.
- Margalit, A (2001) 'Privacy in the Decent Society', *Social Research*, 68 (1) pp 255 - 268.
- Margulis, S (1977) 'Conceptions of Privacy: Current Status and Next Steps', *Journal of Social Issues*, 33 (3) pp 5 - 21.
- Markesinis, B, Ed. (1999) *Protecting Privacy*, Oxford, Oxford University Press.
- Marks, S (1994) 'Intimacy in the Public Realm: the Case of Co-workers', *Social Forces*, 72 pp 843 - 858.
- Marr, H and Pirie, M (1990) 'Setting standards: Protecting Privacy', *Nursing Times*, 86 (13) pp 58 - 59.
- Mason, J (2002) *Qualitative Researching 2nd Edition*, London, Sage Publications.
- Masud, M and Khan, R (1974) *The Privacy of the Self*, London, Karnac Books.
- Matthews, R and Callister, L (2004) 'Childbearing women's perceptions of nursing care that promotes dignity', *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 33 (4) pp 498 - 507.
- Mattiasson, A and Hemberg, M (1998) 'Intimacy - meeting needs and respecting privacy in the care of elderly people: what is a good moral attitude on the part of the nurse/carer?' *Nursing Ethics*, 5 (6) pp 527 - 534.
- Mays, N and Pope, C (1995) 'Qualitative Research: Rigour and qualitative research', *British Medical Journal*, 311 pp 109-112.

- Mccall, G and Simmons, J (1969) *Issues in Participant Observation: a text and reader*, London, Addison-Wesley Publishing Company.
- Mccann, T and Clark, E (2005) 'Using unstructured interviews with participants who have schizophrenia', *Nurse Researcher*, **13** (1) pp 7 - 18.
- Mcculloch, A (1997) 'On the Public and the Private: a comment on Fahey', *Sociology*, **31** (4) pp 793 - 799.
- Mccutcheon, H and Pincombe, J (2001) 'Intuition: an important tool in the practice of nursing', *Journal of Advanced Nursing*, **35** (5) pp 342 - 348.
- Mcdougall, P (1999) 'Focus groups: an overview of their use as a research method', *Community Practitioner*, **72** (3) pp 48 - 49.
- Mcguire, T J (1997) 'Medlineing: why and how to conduct a literature search', *Jems: Journal of Emergency Medical Services*, **22** (4) pp 56-57.
- Mchale, J and Gallagher, A (2003) *Nursing and Human Rights*, London, Butterworth Heinemann.
- Mckinley, J (1972) 'The Sick Role: Illness and Pregnancy', *Social Science and Medicine*, **6** pp 561 - 572.
- Mcparland, J, Scott, P, Arndt, M, Dassen, T, Gasull, M, Lemonidou, C, Valimaki, M and Leino-Kilpi, H (2000) 'Autonomy and clinical practice 2: Patient privacy and nursing practice', *British Journal of Nursing*, **9** (9) pp 566 - 569.
- Meaney, M (2001) Data Mining, Dataveillance, and Medical Information Privacy, In: J Humber and R Almeder (ed), *Privacy and Health Care*, Totowa, Humana Press Inc., 145 - 164.
- Meehan, T, Vermeer, C and Windsor, C (2000) 'Patients' perceptions of seclusion: a qualitative investigation', *Journal of Advanced Nursing*, **31** (2) pp 370 - 377.
- Meerabeau, L (1999) 'The management of embarrassment and sexuality in health care', *Journal of Advanced Nursing*, **29** (6) pp 1507 - 1513.
- Mill, J (1988) *The Subjection of Women*, Indiana, Hackett Publishing Company Inc.
- Mill J Stuart (1982) *On Liberty*, London, Penguin Classics.
- Miller, J and Glassner, B (2004c) The 'inside' and the 'outside': finding realities in interviews, In: D Silverman (ed), *Qualitative Research: Theory, Method and Practice 2nd Edition*, London, Sage Publications, 125 - 139.
- Milligan, M (1987) 'When the lack of privacy gets to your patient', *Registered Nurse*, **March** pp 17 - 18.
- Misago, C, Kendall, C, Freitas, P, Haneda, K, Silveira, D, Onuki, D, Mori, T, Sadamori, T and Umenai, T (2001) 'From 'culture of dehumanization of childbirth' to 'childbirth as a transformative experience': changes in five municipalities in north-east Brazil', *International Journal of Gynaecology and Obstetrics*, **75 Suppl 1** pp S67-72.
- Moorbath, P (1993a) 'Selection of sources on critiquing research and reviewing literature', *Nurse Researcher*, **1** (1) pp 74-78.
- Moore, B (1984) *Privacy: Studies in social and cultural history*, London, M. E. Sharpe Inc.
- Moore, B (1998) 'Privacy', *Society*, **35** (2) pp 287 - 299.
- Morgan, D (1995) 'Why things (sometimes) go wrong in focus groups', *Qualitative Health Research*, **5** (4) pp 516 - 524.

- Morse, J and Field, P (1995) *Qualitative Research Methods for Health Professionals 2nd Edition*, California, Sage.
- Moyle, W (2002) 'Unstructured interviews: challenges when participants have a major depressive illness', *Journal of Advanced Nursing*, **39** (3) pp 266 - 273.
- Nesson, C (2001) 'Threats to Privacy', *Social Research*, **68** (1) pp 105 - 116.
- NHS (2003) *Essence of Care: patient focused benchmarks for clinical governance*, London, NHS Modernisation Agency
- NHS Estates (2002) *Better Health Buildings*, London, Department of Health.
- NHS Executive (1997) *The Patient's Charter: Privacy and dignity and the provision of single sex hospital accommodation*, London, NHS Executive.
- NHS Executive (2000) *Safety, privacy and dignity in mental health units: guidance on mixed sex accommodation for mental health services*, London, Department of Health.
- NICE (2001) *The use of electronic fetal monitoring*, London, National Institute for Clinical Excellence.
- NICE (2003) *Antenatal Care: Routine care for the healthy pregnant women*, London, National Institute for Clinical Excellence
- Nijman, H and Rector, G (1999) 'Crowding and aggression on inpatient psychiatric wards', *Psychiatric Services*, **50** (6) pp 830 - 831.
- Nissenbaum, H (1998) 'Protecting Privacy in an Information Age: The Problem of Privacy in Public', *Law and Philosophy*, **17** pp 559 - 596.
- NMC (2004a) *The NMC Code of Professional Conduct: standards for conduct, performance and ethics*, London, The Nursing and Midwifery Council.
- NMC (2004b) *Midwives Rules and Standards*, London, Nursing and Midwifery Council.
- ONS (2006) *Birth Statistics Series FM1 no 33 (revised)*, London, Office for National Statistics.
- Ormrod, J and Ambrose, L (1999) 'Public perceptions about confidentiality in mental health services', *Journal of Mental Health*, **8** (4) pp 413 - 422.
- Paine, S (2000) *Endangered Species: privacy, law and the home*, London, CAMC Publications.
- Pandiani, J and Banks, S (1998) 'Personal privacy versus public accountability: a technological solution to an ethical dilemma', *Journal of Behavioral Health Services and Research*, **24** (4) pp 456 - 464.
- Parker, R (1974) 'A Definition of Privacy', *Rutgers Law Review*, **27** pp 275 - 296.
- Parrot, T (2005) *Essence of Care Eureka: Privacy and Dignity benchmark: improving privacy and dignity in Acute Mental Health*, London, NHS Modernisation Agency Clinical Governance Support Team
- Pateman, C (1989) *The Disorder of Women: Democracy, feminism and political theory*, Stanford, Stanford University Press.
- Pattison, H and Robertson, C (1996) 'The effect of ward design on the well-being of post-operative patients', *Journal of Advanced Nursing*, **23** (4) pp 820 - 826.
- Peace, S (2003) 'The importance of personal environments', *Nursing and Residential Care*, **5** (4) pp 189 - 191.
- Peace, S and Reynolds, J (2004a) 'Managing different experiences of place and space', *Nursing and Residential Care*, **6** (8) pp 403.

- Peace, S and Reynolds, J (2004b) 'Managing different experiences of place and space: Part two', *Nursing and Residential Care*, **6** (9) pp 452 - 454.
- Peacock, M (2001) *The Private I: Privacy in a public world*, Minnesota, Graywolf Press.
- Pedersen, D (1997) 'Psychological Functions of Privacy', *Journal of Environmental Psychology*, **17** pp 147 - 156.
- Pennock, J and Chapman, W (1971) *Privacy*, New York, Atherton Press.
- Peshkin, A (2000) 'The Nature of Interpretation in Qualitative Research', *Educational Researcher*, **29** (9) pp 5-9.
- Petchey, R, Farnsworth, W and Heron, T (2001) 'The maintenance of confidentiality in primary care: a survey of policies and procedures', *AIDS Care*, **13** pp 251 - 256.
- Peters, D (1993) 'Improving quality requires consumer input: using focus groups', *Journal of Nursing Care Quality*, **7** pp 34 - 41.
- Petronio, S and Kovach, S (1997) 'Managing privacy boundaries: health providers' perceptions of resident care in Scottish Nursing Homes', *Journal of Applied Communication Research*, **25** (2) pp 115 - 131.
- Phillips, R (1996) 'Observation as a method of data collection in qualitative research', *British Journal of Midwifery*, **4** (1) pp 22 - 39.
- Pitt-Payne, T (2003) Privacy Versus Freedom of Information: Is there a Conflict? In: J Cooper (ed), *Privacy: European Human Rights Law Review Special Issue*, London, Sweet and Maxwell Limited, 109 - 119.
- Porter, S (1992) 'Women in a Women's Job: The Gendered Experience of Nurses', *Sociology of Health and Illness*, **14** (4) pp 510-527.
- Post, R (1991) 'Rereading Warren and Brandeis: Privacy, Property and Appropriation', *Case Western Reserve Law Review*, **41** pp 647 - 680.
- Proshansky, H, Ittelson, W and Rivlin, L (1970) Freedom of choice and behaviour in a physical setting, In: H Proshansky, W Ittelson and L Rivlin (ed), *Environmental Psychology*, New York, Rinehart and Winston, p173 - 183.
- Prosser, W (1960) 'Privacy', *California Literature Review*, **383** pp.
- Prosser, W (1984) Privacy: a legal analysis, In: F Schoeman (ed), New York, Cambridge Press, 104 - 141.
- Rachels, J (1975) 'Why privacy is important', *Philosophy and Public Affairs*, **4** pp 323 - 333.
- Randers, I and Mattiasson, A (2004) 'Autonomy and integrity: upholding older adult patients' dignity', *Journal of Advanced Nursing*, **45** (1) pp 63 - 71.
- Rawnsley, M (1980) 'The Concepts of Privacy', *Advanced Nursing Science*, **2** (2) pp 25 - 31.
- RCM (2001) *Midwifery Clinical Practice: The first stage of labour*, London, Royal College of Midwives
- RCN (1993) *Issues in Nursing and Health: Mixed Sex Wards*, London, Royal College of Nursing.
- RCN (2005) *Informed consent in health and social care research: RCN guidance for nurses*, London, Royal College of Nursing.
- Regan, P (1993) 'Ideas or interests: privacy in electronic communications', *Policy States Journal*, **21** (3) pp 450 - 469.
- Reiman, J (1976) 'Privacy, Intimacy and Personhood', *Philosophy and Public Affairs*, **6** pp 26 - 44.

- Reiman, J (1984) Privacy, Intimacy and Personhood, In: F Schoeman (ed), *Philosophical Dimensions of Privacy: an anthology*, Cambridge, Cambridge University Press.
- Reiman, J (1995) 'Driving to the Panopticon: A Philosophical Exploration of the Risks to Privacy Posed by the Highway Technology of the Future', *Santa Clara Computer & High Technology Law Journal*, **11** pp 27 - 44.
- Rich, P (1995) 'Protecting patient information', *Nursing*, **25** (9) pp 32.
- Richards, D (2001) 'Is my body my property?' *Social Research*, **68** (1) pp 83 - 104.
- Richards, T and Richards, L (1991) 'The NUDIST Qualitative Data Analysis System', *Qualitative Sociology*, **14** pp.
- Rosen, J (2001a) 'Out of Context: The Purposes of Privacy', *Social Research*, **68** (1) pp 209 - 220.
- Rosen, J (2001b) *The Unwanted Gaze: the destruction of privacy in America*, New York, Vintage Books.
- Ross, W, Hirt, M and Kurtz, R (1968) 'The fantasy of dirt and attitudes towards body products', *Journal of Nervous and Mental Disease*, **146** pp 303 - 309.
- Rossler, B (2005) *The Value of Privacy*, Cambridge, Polity Press.
- Rowan, K (1993) 'Hospital patients have a right to privacy', *Registered Nurse*, **56** (2) pp 92.
- Ruddick, S (1980) 'Maternal thinking', *Feminist Studies*, **6** pp.
- Rustemli, A (1992) 'Crowding effects of density and interpersonal distance', *Journal of Social Psychology*, **132** pp 51 - 58.
- Rykwert, J (2001) 'Privacy in Antiquity', *Social Research*, **68** (1) pp 29 - 40.
- Rylance, G (1999) 'Privacy, dignity and confidentiality: interview study with structured questionnaire', *British Medical Journal*, **318** pp 301.
- Salecl, R (2002) 'The Exposure of Privacy in Today's Culture', *Social Research*, **69** (1) pp 1 - 8.
- Samoriski, J, Huffman, J and Trauth, D (1996) 'Electronic mail, privacy, and the electronic communications Privacy Act of 1986: Technology in search of law', *Journal of Broadcasting and Electronic Media*, **40** (1) pp 60 - 76.
- Savage, J (2000) 'Participative observation: standing in the shoes of others?' *Qualitative Research*, **10** (3) pp 324 - 339.
- Schatz Byford, K (1998) 'Privacy in Cyberspace: constructing a model of privacy for the electronic communications environment', *Rutgers Computer & Technology Law Journal*, **24** pp 1 - 74.
- Schneider, C (1977) *Shame, Exposure, and Privacy*, London, W. W. Norton & Company.
- Schoeman, F (1992) *Privacy and Social Freedom*, Cambridge, Cambridge University Press.
- Schuster, E (1972) 'Privacy and the hospitalization experience', *Social Science and Medicine*, **10** pp 245 - 248.
- Schwartz, B (1968) 'The social psychology of privacy', *American Journal of Sociology*, **73** pp 741 - 752.
- Scott, J and Keates, D (2004) *Going Public: feminism and the shifting boundaries of the private sphere*, Illinois, University of Illinois Press.
- Scott, P, Taylor, A, Valimaki, M, Leino-Kilpi, H, Dassen, T, Gasull, M, Lemonidou, C and Arndt, M (2003a) 'Autonomy, privacy and informed consent 2: postnatal perspective', *British Journal of Nursing*, **12** (2) pp 117 - 127.

- Scott, P, Taylor, A, Valimaki, M, Leino-Kilpi, H, Dassen, T, Gasull, M, Lemonidou, C and Arndt, M (2003b) 'Autonomy, privacy and informed consent 4: surgical perspective', *British Journal of Nursing*, **12** (5) pp 311 - 319.
- Scott, P, Valimaki, M, Leino-Kilpi, H, Dassen, T, Gasull, M, Lemonidou, C and Arndt, M (2003c) 'Adult/elderly care nursing: Autonomy, privacy and informed consent 3: elderly care perspective', *British Journal of Nursing*, **12** (3) pp 158 - 168.
- Scott, S and Morgan, D (1993) *Body Matters: essays on the sociology of the body*, London, Falmer Press.
- Seidman, I (1998) *Interviewing as Qualitative Research: a guide for researchers in education and the social sciences 2nd Edition*, New York, Teachers College Press.
- Sharts-Hopko, N C (1998) 'Reviewing the literature', *Journal of the Association of Nurses Aids Care*, **9** (5) pp 87-89.
- Silverman, D (2004a) *Qualitative Research: theory, method and practice 2nd Edition*, London, Sage.
- Sim, J (1998) 'Collecting and analysing qualitative data: issues raised by the focus group', *Journal of Advanced Nursing*, **28** pp 345- 352.
- Simmel, A (1971) Privacy in Not an Isolated Freedom, In: J Pennock and J Chapman (ed), *Privacy*, New York, Atherton.
- Sloan, G (1998) 'Focus group interviews: defining clinical supervision', *Nursing Standard*, **12** (42) pp 40 - 43.
- Smith, J M (1997) *Private Matters: in defense of the personal life*, Harlow, Addison-Wesley Publishing Company Inc.
- Sommers, R (1959) 'Studies in Personal Space', *Sociometry*, **22** pp 247 - 260.
- Spacks, P (2003) *Privacy: Concealing the Eighteenth Century Self*, London, University of Chicago Press.
- Spouse, J (1997) 'Issues in observing nursing students in clinical practice', *Nursing Times Research*, **2** (3) pp 187-196.
- Stein, L W (1993) 'Living with the Risk of Backfire: a Response to the Feminist Critiques of Privacy and Equality', *Minnesota Law Review*, **77** pp 1153 - 1191.
- Steiner, I (1970) Percieved Freedom, In: L Berkowitz (ed), *Advances in Experimental Social Psychology Volume 5*, New York, Academic Press.
- Stratton, L, Tekippe, D and Flick, G (1973) 'Personal space and self concept', *Sociometry*, **36** (3) pp 424 - 429.
- Strauss, A (1987) *Qualitative Analysis for Social Scientists*, Cambridge, Cambridge University Press.
- Strauss, A (1994a) Awareness Contexts and Grounded Formal Theory, In: B Glaser (ed), *More Grounded Theory Methodology: a reader*, Mill Valley, USA, Sociology Press, 360 - 368.
- Strauss, A (1994b) Discovering New Theory from Previous Theory, In: B Glaser (ed), *More Grounded Theory Methodology: a reader*, Mill Valley, USA, Sociology Press, 369 - 376.
- Strauss, A and Corbin, J, Eds. (1997) *Grounded Theory in Practice*, London, Sage Publications.
- Strauss, A and Corbin, J (1998a) *Basics of Qualitative Research: techniques and procedures for developing grounded theory 2nd Edition*, London, Sage Publications.

- Strauss, A and Corbin, J (1998b) Grounded Theory Methodology: an overview, In: N Denzin and Y Lincoln (ed), *Strategies of Qualitative Inquiry*, London, Sage Publications, 158 - 183.
- Strauss, A, Fagerhaugh, S, Suczek, B and Wiener, C (1981) 'Patients' work in the technologized hospital', *Nursing Outlook*, **29** pp 404 - 412.
- Strauss, A, Fagerhaugh, S, Suczek, B and Wiener, C (1982) 'The work of hospitalized patients', *Social Science and Medicine*, **16** pp 977 - 986.
- Strong, P (1979) *The Ceremonial Order of the Clinic*, London, Routledge and Kegan Paul.
- Swanson, J, Ed. (1986) *The formal qualitative interview for grounded theory*, From practice to grounded theory: qualitative research in nursing, Wokingham, Addison Wesley.
- Swenson, J and Griswold, W (1992) 'Focus Group', *Small Group Research*, **23** (4) pp 459 - 475.
- Symonds, A and Hunt, S (1996) *The Midwife and Society: Perspectives, Policies and Practice*, Basingstoke, Macmillan.
- Synnott, A (1992) 'Tomb, temple, machine and self: the social construction of the body', *British Journal of Sociology*, **43** (1) pp 79-110.
- Tabak, N and Ozon, M (2004) 'The influence of nurses' attitudes, subjective norms and perceived behavioral control on maintaining patients' privacy in a hospital setting', *Nursing Ethics*, **11** (4) pp 366 - 377.
- Tate, J (1980) 'The need for personal space in institutions for the elderly', *Journal of Gerontological Nursing*, **6** pp 439 - 448.
- Tishelman, C, Bernhardson, B, Blomberg, K, Borjeson, S, Franklin, L, Johansson, E, Levealahti, H, Sahlberg-Blom, E and Ternestedt, B (2004) 'Complexity in caring for patients with advanced cancer', *Journal of Advanced Nursing*, **45** (4) pp 420 - 429.
- Travers, A, Burns, E, Penn, N, Mitchell, S and Mulley, G (1992) 'A survey of hospital toilet facilities', *British Medical Journal*, **304** (6831) pp 878 - 879.
- Twigg, J (1999) 'The spatial ordering of care: public and private in bathing support at home', *Sociology of Health and Illness*, **21** (4) pp 381 - 400.
- UKCC (1992) *The Scope of Professional Practice*, London, United Kingdom Central Council for Nursing Midwifery and Health Visiting.
- UKCC (1996) *Guidelines for Professional Practice*, London, United Kingdom Central Council for Nursing, Midwifery and Health Visiting.
- UKCC (1998) *Midwives Rules and Code of Practice*, London, United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC).
- UKCC (1999) *Practitioner-client relationships and the prevention of abuse*, London, United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC).
- UNICEF (2001) *Implementing the Baby Friendly Feeding Best Practice Standards*, London, UNICEF UK BFI.
- Universal Declaration of Human Rights, Article 12 (1948), <http://www.hrweb.org/legal/udhr.html>. 2005.
- Vail, D (1966) *Dehumanization and the Institutional Career*, Springfield, Charles Thomas.
- Webb, C and Kevern, J (2001) 'Focus groups as a research method: a critique of some aspects of their use in nursing research', *Journal of Advanced Nursing*, **33** (6) pp 798 - 805.
- Westin, A (1967) *Privacy in Western History*, New York.

- Westin, A (1970) *Privacy and Freedom*, London, The Bodley Head.
- Whitbeck, C (1993) The Maternal Instinct, In: J Trebilcot (ed), *Mothering Essays in Feminist Theory*, Lanham, Rowman and Littlefield.
- White, A (2003) Data Protection and the Media, In: J Cooper (ed), *Privacy: European Human Rights Law Review Special Issue*, London, Sweet and Maxwell Limited, 25 - 36.
- White, G and Thomson, A (1995) 'Anonymized focus groups as a research tool for health professionals', *Qualitative Health Research*, 5 (2) pp 256 - 262.
- WHO (1992) The International Definition of a Midwife, <http://www.who.int/reproductive-health/publications>. 2006.
- Willcocks, D and Peace, S (1987) *Private Lives in Public Places*, London, Tavistock Publications.
- Williams, C (1991) 'Preserving dignity through care', *Nursing Times*, 87 (3) pp 46 - 49.
- Williams, R (1976) *Keywords: a vocabulary of culture and society*, London, Fontana Press.
- Woogara, J (2001) 'Human rights and patients' privacy in UK hospitals', *Nursing Ethics*, 8 (3) pp 234 - 245.
- Woogara, J (2004) 'Patients' rights to privacy and dignity in the NHS', *Nursing Standard*, 19 (18) pp 33 - 37.
- Young, J (1978) *Privacy*, Chichester, John Wiley and Sons.
- Zhang, J, Klebanoff, M and Dersimonian, R (1999) 'Epidural analgesia in association with the duration of labour and mode of delivery: a quantitative review', *American Journal of Obstetrics and Gynecology*, 180 (4) pp 970 - 977.

Appendix 1: Consent Form

**School of Health and
Social Welfare**

The Open University
Walton Hall
Milton Keynes
MK7 6AA
Telephone (01908) 274066
Direct Line (01908) 65
Telex 825061
Fax (01908) 654124

Dr Linda J Jones
Dean

Centre Number:

Study Number:

Client Identification Number for the project:

Title of Project:

Privacy - What it means to you

Name of Researcher:

Barbara Burden

Please initial box

1. I confirm that I have read and understand the information sheet dated *****
(version) for the above study and have had the opportunity to ask
questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any
time, without giving any reason, without my midwifery care or legal rights being
affected, and that the tape recording may be destroyed where necessary.
3. I understand that sections of my medical notes may be looked at by the researcher
stated above from the Open University, where it is relevant to my taking part in the
research. I give permission for this person to have access to my records.
4. I agree to take part in the above study.

Name of client: _____ Date: _____ Signature: _____

Name of researcher _____ Date: _____ Signature: _____

(adapted from Milton Keynes (Local) Research Ethics Committee Consent Form March 1999)

Appendix 2: Focus group schedule checklist

Activity	Done
a. Greet participants as they arrive and offer refreshments	
b. Welcome the participants once settled.	
c. Ensure participants are comfortable.	
d. Introduce myself.	
e. Enable the participants to introduce themselves.	
f. Thank all members for participating.	
g. Explain the purpose of the focus group.	
h. Confirm the theme of the focus group.	
i. Confirm that participants have received information sheets.	
j. Explain participants their rights: <ul style="list-style-type: none"> • Right to withdraw at any time • Right to have their views removed from the transcript (where possible – explain) • Explain what will happen following focus group (transcribing etc) 	
k. Discuss issues of confidentiality and anonymity.	
l. Discuss security of data	
m. Identify the format of the session. For example, it represents a debate.	
n. Identify the key areas for discussion (if required).	
o. Confirm the use of audio or visual recorders.	
p. Confirm that each participant has equal rights and the right to be heard.	
q. Reassure participants that there are no right or wrong answers, and they should respect each other's opinions.	
r. State how long the session will last.	
s. Outline the role of the facilitator.	
t. Explain the process of the focus group.	
u. Provide the opportunity to ask questions.	
v. Confirm that all participants agree to participate.	
w. Turn on the recording equipment.	
x. Introduce your key statement or question and commence the focus group.	
y. Ask them to start by stating their view or experience of the focus group topic.	
<i>At the end of the session</i> <ul style="list-style-type: none"> • Offer debriefing where required. • Reconfirm issues of confidentiality. • Thank all participants. 	

Date completed:
Signed
Group:
Focus Group Number:

BBurden 2003

Appendix 3: Publications and Conference Presentations

Publications:

Burden B 2001 Writing a review of the literature: a practical guide, *British Journal of Midwifery*, 9 (8) pp 498 - 501

Burden B J 1998 Privacy or Help? The use of curtain positioning strategies within the maternity ward environment as a means of achieving and maintaining privacy, or as a form of signalling to peers and professionals in an attempt to seek information or support, *Advanced Journal of Nursing* 27 (1) pp 15 – 23.

Conference Presentations:

2005 Burden B From Data to Discussion, Postgraduate Research Conference, The Open University, September.

2005 Burden B Privacy: Privacy in maternity care environments: a mother's view, Maternity Services Liaison Committee, Bedford

2004 Burden B Privacy: Women's views of privacy in maternity care environments, Postgraduate Research Conference, The Open University, June.

2003 Burden B Women and Privacy, Bedfordshire Primary Care Research Network, Silsoe Conference Centre, Bedfordshire, June

2002 Burden B Privacy in midwifery practice environments, International Confederation of Midwives 26th Triennial Congress, Vienna, April

2001 Local Ethics Committees: done that, now try this, Open University Research Conference, London

1998 Privacy in the ward environment: a study of the social construction of privacy by individuals within an institutional setting, Postnatal Care Conference, University of Hull